COPY

-Application

Professional Home Health d/b/a CareAll Homecare Services

CN1312-049

CareAll
Home Care Services

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building
500 Deaderick Street, 9th Floor
Nashville, TN 37243

Dear Director,

This is a request for the CON Application submitted December 13, 2013 for the relocation of the principle office from Covington, Tipton County, to Brownsville, Haywood County of Professional Home Health Care, LLC D/B/A/ CareAll Homecare Services to be placed on the Consent Calendar to be heard in February.

The CON Application fee is not included with the application and will be sent separately but will be received simultaneously.

Sincerely,

Mary Ellen Foley
Project Director
CareAll Management, LLC

Letter of Intent
Submitted 12/10/2013

DEC 13'13 09:59

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor 502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

LETTER OF INTENT

The Publication of Intent is to be published in the Jackson Sun (Name of Newspaper) which is a newspaper of general circulation in Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lauderdale, McNairy, Madison, Obion, Tipton, and Weakley (County) Tennessee, on or before December 10, (Month/day) , 2013 (Year), for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that: Professional Home Health Care, LLC D/B/A CareAll Homecare (Name of Applicant) Home Health Agency (Facility Type-Existing) owned by: CareAll, LLC with an ownership type of a Limited Liability Company and to be managed by: CareAll Management, LLC intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]: Relocation of the home health agency parent(or principle) office from 901 Highway 51 South, Covington, Tipton county, Tennessee to the current location of its Brownsville branch office at 1151 Tammbell Street, Brownsville, Haywood county, Tennessee. Professional Home Health Care, LLC is licensed to serve Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lauderdale, McNairy, Madison, Obion, Tipton, and Weakley. Existing home care services will not be affected, and no service will be initiated or discontinued. The project does not impact patient care, involves no construction or capital expenditure or the acquisition or modification of any item of major medical equipment. Anticipated project cost is $ 59,300.

The anticipated date of filing the application is: December 13, 2013

The contact person for this project is Mary Ellen Foley (Contact Name) Project Director (Title) who may be reached at:

CareAll Management, LLC (Company Name) 326 Welch Road (Address)

(City) Nashville (State) Tennessee (Zip Code) 37211 615-331-6137 (Area Code / Phone Number)

Mary Ellen Foley (Signature) 12-09-2013 (Date)

mfoley@careallinc.com (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the agency.

Certificate of Need Application

Professional Home Health Care, LLC D/B/A

CareAll Homecare Services

December 13, 2013

DEC 13 '13 AM 9:52

1. ***Name of Facility, Agency, or institution***

Professional Home Health Care, LLC D/B/A CareAll Homecare Services

Name | 1151 Tammbell Street | Haywood

Street or Route | Brownsville | TN 38012 | County

City | State | Zip Code

2. ***Contact Person Available for Responses to Questions***

Mary Ellen Foley | Project Director

Name | Title

Company Name CareAll Management, LLC | Email address mfoley@careallinc.com

Street or Route 326 Welch road | City Nashville | State TN | Zip Code 37211

Association with Owner-employee | Phone Number-731-514-1618 | Fax Number-731-587-3228

3. ***Owner of the Facility, Agency or Institution***

CareAll, LLC | 615-331-6137

Name | Phone Number

Street or Route 329 Welch Road | County Davidson

City Nashville | State TN | Zip Code 37211

4. ***Type of Ownership of Control (Check One)***

A. Sole Proprietorship
B. Partnership
C. Limited Partnership
D. Corporation (For Profit)
E. Corporation (Not-for-Profit)
F. Government (State of TN or Political Subdivision)
G. Joint Venture
H.
I. Limited Liability Company X
Other (Specify)

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

(2)

5. ***Name of Management/Operating Entity (If Applicable)***

CareAll Management, LLC

Name

Street or Route 326 Welch Road County Davidson

City Nashville State Tennessee Zip Code 37211

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. ***Legal Interest in the Site of the Institution (Check One)***

A.	Ownership	D.	Option to Lease
B.	Option to Purchase	E.	Other (Specify)
C.	Lease of 3 Years x		

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

7. ***Type of Institution (Check as appropriate--more than one response may apply)***

A.	Hospital (Specify)	I.	Nursing Home
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty	J.	Outpatient Diagnostic Center
		K.	Recuperation Center
C.	ASTC, Single Specialty	L.	Rehabilitation Facility
D.	Home Health Agency x	M.	Residential Hospice
E.	Hospice	N.	Non-Residential Methadone Facility
F.	Mental Health Hospital		
G.	Mental Health Residential Treatment Facility	0.	Birthing Center
		P.	Other Outpatient Facility (Specify)
H.	Mental Retardation Institutional Habilitation Facility (ICF/MR)	Q.	Other (Specify)

office

8. **Purpose of Review *(Check) as appropriate--more than one response may apply)***

A.	New Institution	G.	Change in Bed Complement *[Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation]*
B.	Replacement/Existing Facility		
C.	Modification/Existing Facility		
D.	Initiation of Health Care Service as defined in TCA § 68-11-1607(4) (Specify)	H.	Change of Location
E.	Discontinuance of OB Services	I.	Other (Specify) relocation of the principle office
F.	Acquisition of Equipment		

(3)

9. **Bed Complement Data**

Please indicate current and proposed distribution and certification of facility beds.

		TOTAL
A	Medical	
B	Surgical	
C	Long-Term Care Hospital	
D	Obstetrical	
E	ICU/CCU	
F	Neonatal	
G	Pediatric	
H	Adult Psychiatric	
I	Geriatric Psychiatric	
J	Child/Adolescent Psychiatric	
K	Rehabilitation	
L	Nursing Facility (non-Medicaid Certified)	
M	Nursing Facility Level 1 (Medicaid only)	
N.	Nursing Facility Level 2 (Medicare only)	
0.	Nursing Facility Level 2 (dually certified Medicaid/Medicare)	
P.	ICF/MR	
Q	Adult Chemical Dependency	
R	Child and Adolescent Chemical Dependency	
S	Swing Beds	
T.	Mental Health Residential Treatment	
U	Residential Hospice	
	TOTAL	

*CON-Beds approved but not yet in service

10. **Medicare Provider Number 44-7503**

Certification Type Home Health Agency _____

11. **Medicaid Provider Number 44-7503**

Certification Type Home Health Agency _____

12. **If this is a new facility, will certification be sought for Medicare and/or Medicaid? NA**

13. ***Identify all Tenn Care Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.*** **Will this project involve the treatment of TennCare participants? yes If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted *or plans to contract.***

Section: Applicant profile, Item 3
Response: see attached corporate charter and certificate of corporate existence.

Section A: Applicant Profile, Item 4
Describe the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% or more ownership interest.
Response: Professional Home Health Care, LLC D/B/A CareAll Homecare Services is 100% owned by CareAll, LLC. CareAll, LLC is 98% owned by CareAll, Inc. and 2% owned by the estate of James W. Carell. See attached chart of the ownership structure of CareAll, Inc.

In addition, please document the financial interest of the applicant, and applicant's parent/owner in any other health care institutions as defined in Tennessee code Annotated, 68-11-1602 in Tennessee. At a minimum please provide the name, address, current status of licensure/certification, and percentage of ownership of each health care institution identified.
Response: CareAll, LLC owns 100% of the following other health care institutions in Tennessee.
University Home Health, LLC-135 Kennedy Drive, Martin, TN, 38237-license #276.
VIP Home Nursing & Rehabilitation Service, LLC- 4015 Travis Drive, Suite 102, Nashville, TN 37211-license #295.
JW Carell Enterprises, LLC-Knoxville- 118 Mabry Hood Road, Suite 100, Knoxville, TN 37922-license #131.
JW Carell Enterprises, LLC-McMinnville- 200 Hobson Street, Suite 44, McMinnville, TN, 37110-License #265.

Section A: Applicant Profile, Item 5
For facilities with existing management agreements, attach a copy of the fully executed final contract.
Response: see attached management agreement.
Please describe the management entity's experience in providing management services for the type of facility, which is the same or similar to the applicant facility. Please describe the ownership structure of the management entity.
Response: CareAll Management has provided billing, financial and clinical over site services since 1986 for this agency. The structure of CareAll Management, LLC is held in 5 sub-trusts under the JWC Dynasty Trust as follows: Michael Carell Exempt Trust-20%, Eileen Carell Exempt Trust-20%, James M. Carell Exempt Trust-20%, Richard Carell Exempt Trust-20%, and Christine Carell Exempt Trust-20%.

Section A: Applicant Profile, item 6
Attach a copy of the fully executed lease agreement for the project location.
Response: See attached lease agreement.

Section A: Applicant Profile, Item 13
Please identify all MCOs/BHOs with which the applicant has contracted or plans to contract.

BlueCare
TennCare Select

Section B, Project Description, Item 1

Provide a brief executive summary of the project including a brief description of propose services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

Response:

The project consists of relocation of the principle office of Professional Home Health Care, LLC D/B/A CareAll Homecare Services from the current location of 901 Highway 51 South, Covington, Tipton County, Tennessee, 38019 to 1151 Tammbell Street, Haywood County, Brownsville, TN 38012. The purpose of this project is: 1. to situate the principle office in a centralized location to the other branch offices within the agency. See attached map of area and the proximity to the branch offices.

2. To relocate the principle office to a location that has a larger percentage of the agency's patient census. The Covington office currently has a patient census of 19. The Brownsville location has the largest census of any of the offices and is currently at 124. Total agency census is 450. 3. To have the ability to reduce cost by closing the Covington location and incorporating the current service area of the Covington location with the service area of the Ripley and Brownsville locations. This cost reduction will be projected at $245,544 annually. The ownership structure will not change. The current service area will not change. The project will eliminate 2 staff member positions including the Director of Patient Services and the office Coordinator in the Covington location with an annual cost savings of $61,720.00 included in the total cost reduction of $245,544. The current field staff will continue to service the patients in their assigned areas. The project cost will involve the filing fee of $3,000, the cost of preparing the letter of intent and application of$2,500, the cost of moving the contents of the Covington location and other miscellaneous and organizational cost of $7,000, and the cost of the lease of the new principle office of Brownsville which is $46,800. The total cost of the project is $59,300. The funding will be provided by existing cash reserves.

Section B, Project Description, Item 2

Provide a detailed narrative of the project by addressing the following items as they relate to the proposals.

A. *Describe the development of the proposal.*

Response:

The Covington office will be closed. The staff positions in that office of Director of Patient Services and Office Coordinator will be eliminated with a savings annually of $61,720. The new principle location in Brownsville and the Ripley branch location will provide the clinical support to the territory previously served by the Covington office. The clinical field staff will be transferred to either the Brownsville office or the Ripley office depending on the service area that the staff members cover. The reimbursement will decrease by the relocation of the parent office. Tipton County which is the current location of the principle office has a CBSA urban rate with a wage index of 0.9275. The proposed new location in Brownsville, TN is a rural CBSA with a wage index of 0.7734.

B. *Describe the need for change and if it will have an impact on existing services.*

Response:

The proposed new principle location, which is currently operating as the agency's existing branch office site contains 2300 square feet. No new construction is required for the relocation of the agency's principle office to the Brownsville office, as the principle office will occupy the current space. This change will have little or no impact on existing services.

C. *As the applicant, describe your need to provide the following health care services.*

Response:

The agency will provide home health services with no change in service area or type of services provided by changing the location of the principle office.

D. *Describe the need to change location or replace an existing facility.*

Response:

The agency's rational for relocating the principle office from Covington to Brownsville is: 1. to centrally locate the principle office to the branch offices for better availability to the administrative staff. 2. to relocate the principle office to an office with a larger percentage of the agency's patient census to streamline the operations. 3. Medicare episodic payments for home health have decreased 10% to 14% over the last two years and TennCare payments for private duty and home health have decreased by approximately 6% in the same time period. CMS projects that the Medicare payments to home health agencies in calendar year 2014 will be reduced by an additional 1.5% (see attached reference from the CMS website). The closing of the Covington office which has a small percentage of the agency census and placing the principle location in Brownsville which has a larger percentage of the agency census will result in an annual savings of $245,544. This savings will thereby offset some of the declines in reimbursement.

E. *Describe the acquisition of any item of major medical equipment which exceeds a cost of $1.5 million.*

Response:

There will be no acquisition of any items of major medical equipment with this proposal.

Section B, Project Description, Item 3

A. *Attach a copy of the site on a 8 1/2" x 11" sheet of white paper which must include:* (see attached).
   1. *Size of site (in acres).* ***Response:*** One acre.
   2. *Location of the structure on the site:* ***Response:*** The area of the building and parking lot is one acre. The Brownsville office leases a suite of 2300 square feet within the building that has a total of 7500 square feet of space.
   3. *Location of proposed construction.* ***Response:*** No proposed construction.
   4. *Names of streets, roads or highways that cross or border the site.* ***Response:*** (See plot of the site attached).

B. 1. *Describe the relationship of the site to public transportation routes, if any, and to any highway of major road developments in the area. Describe the accessibility of the proposed site to patient/clients.* ***Response:*** The Brownsville office is situated in close proximity to Interstate 40 for the east and west routes and Highway 51 for the north and south routes. These highways give the staff excellent access to the agency's patient/clients as well as the other branch locations from the principle office (see attached google map of the area).

Section B, Project Description, Item 4
Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms, ancillary area, equipment areas, etc. on an 8 ½" x 11" sheet of white paper.
Response: See attached floor plan drawing.

Section B, Project Description, Item 5

For Home health Agency or Hospice, identify:

1. *Existing service area by county.* ***Response:*** The existing service area of Professional Home Health Care, LLC D/B/A CareAll Homecare Services consists of Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lauderdale, McNairy, Madison, Obion, Tipton, and Weakley.
2. *The proposed service area.* ***Response:*** The existing service area will not change with the relocation of the principle office from Covington to Brownsville.
3. *A parent or primary service provided.* ***Response:*** The proposal is to relocate the primary location from Covington to Brownsville.
4. *Existing branches:* ***Response:*** Ripley, Alamo, Jackson, and Henderson will remain.
5. *Proposed branches:* ***Response:*** We propose to close the Covington location and make the Brownsville office the principle location.

Section C: General Criteria for Certificate of Need

Item 1, Need

1. *Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for growth.*

Response:

The agency seeks to relocate its principle office from Covington to Brownsville. Because the relocation does not involve the initiation or cessation of any health care services, the acquisition of any equipment or the construction of a new facility, not all five principles for achieving better health directly apply to the project.

1. ***Health Lives:*** The purpose of the State Health Plan is to improve the health of Tennesseans. Professional Home Health Care, LLC has been providing high quality, comprehensive home health services to the residents of West Tennessee for over 25 years. The agency treats each patient through a variety of disciplines, including skilled nursing, home health aide services, occupational, speech and physical therapy, medical social services, private duty nurses and aide services, and attendant and companion services with respect and dignity. The Agency cooperates with hospitals, nursing homes, and other health care facilities in an attempt to maximize the quality of life of its patients.
2. ***Access to Care:*** Every citizen should have reasonable access to health care. The Agency serves Medicare, TennCare, and private pay patients. The Agency's patients include the demographic spectrum. The Agency denies access to no one.
3. ***Economic Efficiencies:*** The State's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies, and the continued development of the State's health plan. The relocation of the Agency's principle office from Covington to Brownsville will result in an annual savings of $245, 544. That savings, even in the face of declining reimbursement rates from Medicare and TennCare, will assist the Agency in achieving economic efficiencies and to continue to deliver high quality health services.
4. ***Quality of Care:*** Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers. The Agency has a long history of providing high quality care to its patients. The relocation of the principle office from Covington to Brownsville will place the administration in a centralized location to the service area resulting in a more efficient monitoring of staff and patient care.
5. ***Health Care Workforce:*** *The State should support the development, recruitment, and retention of a sufficient and quality healthcare work force. The Agency currently has 172 FTE's. All of the Agency's employees have been trained in the delivery of high quality health care and are licensed as appropriate. The Agency provides all staff with ongoing comprehensive continuing education programs as well as assistance in completion of formal education. Further, the Agency periodically assists through preceptor programs in training nurses and therapy students in home care delivery.*

Section C, Need, Item 1 a.

Please provide a response to each criterion and standard in certificate of need categories that are applicable to the proposed project.

Response:

We have used page 41 of 54 which outlines the criteria specific to Home Health Services. Criteria #1 and #2 which address need is not applicable to this project due to no services will be deleted or added to the Agency's certified area.

Criteria #3: *Using recognized population sources, projections for four years will be used:* ***Response:*** see attached Tennessee resident Population Home health Patient totals and the ratio from years 2010 and 2011.

Criteria #4: The use rate of existing home health agencies in the county will be determined by examining the latest utilization rate as calculated in the Joint Annual Report of existing home health agencies in the service area. ***Response:*** See attached historical JAR data from the existing home health agencies in the services area which is covered by Professional Home Health Care, LLC D/B/A CareAll Homecare Services. See attached JAR report information. Based on the historical information provided comparing other home health agencies in the service area the projected totals for Professional Home Health Care, LLC D/B/A CareAll Homecare Services patients served in 2015 would be 1435 and in 2016-1522.

Criteria #5: ***Response:*** NA

Criteria #6:

a. *The average cost per visit by service category shall be listed.*
   Response:
   SN $69.00
   PT $95.00
   MSS $82.00
   Aide $26.00
   OT $95.00
   ST $95.00

b. *The average cost per patient based upon the projected number of visit per patient shall be listed.*
   Response: The average cost per visit is calculated at $110.60 using the current JAR report calculation of total number of visits made divided by the total number of patients served and that number divided by the average cost per visit.

Item 1, b: ***Response:*** NA

Section C, Need, Item 2

Describe the relationship of this project to the applicant facility's long-range development plans, if any.

Response:

The Agency anticipates the continuation of the current trend of decreasing reimbursement rates for its services from both Medicare and TennCare. Accordingly, the Agency's financial success depends upon its achieving cost savings where it can do so without compromising patient care. Relocating the principle office from Covington to Brownsville achieves not only better administrative over site but some of those cost savings and will have no negative impact on patient care.

Section C, Need, Item 3

Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area.

Response:

Please see attached map of the current certified service area of Professional Home Health Care, LLC D/B/A CareAll Homecare services. This service area will not change with this proposed project.

Section C, Need, Item 4

A. *Describe the demographics of the population to be served by this proposal.*

Response:

The primary demographic area to be served is largely rural and the primary population is over 75 with Medicare benefits. The next largest patient population is 18-64 years of age which includes a large portion of individuals with TennCare benefits. Many from this younger patient population require private duty and long-term care services.

B. *Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.*

Response:

Much of the Agency's service area is rural and economically depressed. A large percentage of the individuals residing in the service area are eligible for TennCare and/or Medicare. The agency provides private duty services under TennCare which also includes the Choices program. Through these programs for which the Agency participates, they are able to serve those areas of the population with special needs including health disparities, elderly, women, children, racial and ethnic minorities, and low-income groups. The Agency has provided care to these patient populations throughout its existence and will continue to do so.

Section C, Need, Item 5

Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

Response:

Please see attached list of other home health agencies by base county providing services in the 19 county service areas. Included in the list are total patients and total patient visits for each agency for

the current and last three reporting years. No agency is based in the following 6 counties of the Agency's service area: Chester, Crockett, Hardeman, Haywood, Lauderdale, and McNairy.

Section C, Need, Item 6
Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.
Response:
Please see attached utilization chart for Professional Home Health, LLC D/B/A CareAll Homecare services. The projection methodology was provide through a comparison of current trends in patient census and visit counts and as they compare to previous years.

Section C, Economic Feasibility

Project Cost Chart

Economic Feasibility Item 1

PROJECT COSTS CHART

A.	Construction and equipment acquired by purchase:	
1.	Architectural and Engineering Fees	0
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$2,500
3.	Acquisition of Site	0
4.	Preparation of Site	0
5.	Construction Costs	0
6.	Contingency Fund	0
7.	Fixed Equipment (Not included in Construction Contract)	0
8.	Moveable Equipment (List all equipment over $50,000)	0
9.	Other (Specify) moving cost, miscellaneous organizational cost	$7,000
B.	Acquisition by gift, donation, or lease:	
1.	Facility (inclusive of building and land)	$46,800
2.	Building only	0
3.	Land only	0
4.	Equipment (Specify) _____	0
5.	Other (Specify) _____	0
C.	Financing Costs and Fees:	
1.	Interim Financing	0
2.	Underwriting Costs	0
3.	Reserve for One Year's Debt Service	0
4.	Other (Specify) _____	0
D.	Estimated Project Cost (A+B+C)	$56,300
E.	CON Filing Fee	$3,000
F.	Total Estimated Project Cost (D+E) TOTAL	$59,300

Section C: Economic Feasibility

Item 2:

Identify the funding sources for this project.

Response: E. Cash reserves- see attached documentation from Chief Financial Officer.

Item 3:

Discuss and document the reasonableness of the proposed project cost. If applicable, compare the cost per square foot of construction to similar projects recently approved by the health Services and Development Agency.

Response: This project involves no construction, real or personal property acquisition or initiation of new services. The Agency simply seeks to relocate its parent office from Covington, Tipton County, to Brownsville, Haywood County. Accordingly the administrative cost of $2500 and the moving cost of approximately $7,000 are reasonable and necessary to effectuate this project. These sums together with the filing fee of $3,000 and the three year lease agreement for the office location of $46,800 totals the cost of the project at $59,300. This project is similar to the CON that was granted to VIP Home Nursing and Rehabilitation Service, LLC with the move of the principle location from Lebanon, Wilson County, to Nashville, Davidson County on October 24, 2012.

Item 4:

Complete Historical and Projected Data Charts on the following two pages. Historical Data chart represents revenue and expense information for the last three (3) years for which complete data is available for the institution. Project Data Chart requests information for the two (2) years following the completion of this proposal. Project Data Chart should reflect revenue and expense projections for the PROPOSAL ONLY.

Response: See attached Historical Data Charts for 2010, 2011, 2012, and Projected Data Charts for 2014, and 2015.

Item 5:

Please identify the projects average gross charge, average deduction from operating revenue, and average net change.

Response: There should be no change in the average gross charge, average deduction from operating revenue, or average net change as a result of this proposed project of relocating the principle location from Covington, Tipton County, to Brownsville, Haywood County.

Item 6:

a. *Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.*

   Response: SN-$126.00
   PT-$150.00
   MSS- $192.00
   Aide-$ 86.00
   OT- $150.00
   ST- $150.00

There is no anticipated change in rates due to the proposed relocation of the principle location from Covington to Brownsville. This change will have no impact on revenue or on existing patient charges.

b. *Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Service and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).*
Response: See attached chart of home health agencies providing services in the same or adjoining area as Professional Home Health Care, LLC and their charges as reported on the current JAR.

Item 7:
Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.
Response: The projected utilization rates should show no change by relocating the principle office from Covington, Tipton County, to Brownsville, Haywood County. The cost-effectiveness should be enhanced as a result of this proposed project of the relocation of the principle office to Brownsville and closing of the Covington location.

Item 8:
Discuss how financial viability will be ensured within two years: and demonstrate the availability of cash flow until financial viability is achieved.
Response: Given the limited scope of the project, the Agency's current financial viability will not be affected by this project. Not including the value of the three year lease, which is $46,800, the total project cost are $12,500, payable from cash reserves. Cash flow will not be affected. See letter from Chief Financial Officer, regarding cash reserves, attached as Attachment C-Economic Feasibility -Item 2.

Item 9:
Discuss the projects participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare or other state and federal sources for the proposal's first year of operation.
Response: The Agency is Medicare certified and participates in the TennCare program. The agency contracts with BlueCare/TennCare Select for services. In 2010, 58% of the Agency's revenues, or $11,714,458, was from the Medicare program, and 36.38% or $7,302,126 were from the TennCare/Medicaid program. In 2011, 57.32% of the Agency's revenues, or $10,768,956 was from the Medicare program, and 34.77%, or $6,532,390, were from the Tenncare/Medicaid program. In 2012, 55.98%, or $8,940,611 were from the Medicare program and 33.53%, or $45,355,102 from the TennCare/Medicaid program. We anticipate that these percentages will not change within the year following approval of the project as a result of moving the principle location from Covington to Brownsville.

Item 10:
Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved

with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility –Item 10.
Response: Balance sheet and other financial statements as of October 30, 2013 are attached as Attachment C-Economic Feasibility- Item 10.

Item 11:
Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

a. *A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.*
Response: The alternative to moving the Agency's principle location from Covington, Tipton County, to Brownsville, Haywood County, would be to leave the principle office in Covington. This alternative would not provide the necessary cost reduction of $245,544 provided by closing the Covington office. This alternative would also not provide the Agency with a more centralized location to the branch offices which would provide the Agency with better access to Administrative staff and assist in streamlining efficiency in the Agency operations.

b. *The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.*
Response: There is no new construction involved in this project. This project is considered superior to the alternative and is a modernization and sharing arrangement. This project will provide the opportunity to close the Covington location which has a very small percentage of the Agency's census, is not centrally located to the Agency's other branch offices and can provide a cost savings to the Agency of approximately $245,544 annually. This cost saving is necessary in lieu of the continued Medicare as well as TennCare payment reductions previously discussed.

Section C: Contribution to the Orderly Development of Health Care

1. *List all existing health care providers (e.g. hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/ or working relationships, e.g., transfer agreements, contractual agreements for health services.*
   Response: Professional Home Health Care, LLC currently has a contractual relationship with Blue Care/TennCare Select to provide TennCare serves in West Tennessee. The Agency has attempted to contract with United Healthcare (Amerigroup) in the past. The Agency will attempt to establish contractual relationships will all three Tennessee MCO's when the contract awards are announced for 2015.

2. *Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service are of the project.*
   Response: The project proposal of moving the principle office of Professional Home Health Care, LLC from Covington, Tipton county , to Brownsville, Haywood county should have no negative effect on the health care system in the area. There will be no additions, duplication or competition arising from this project. This project involves no additional services to the existing service area. Haywood County currently has no other principle home health location which could be considered duplication. The utilization rates of existing providers in the service area should not be affected due to this project due to the fact that this project proposes no change to the service area or change in services provided by this Agency.

3. *Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee department of Labor & Workforce Development and/ or other documented sources.*
   Response: See attached schedule of staff FTE's for each staff position, current and proposed. The net change proposed for FTEs and the average agency annual wage for each position as compared to the state annual wage for each professional position and overall annual wage for the service area.

4. *Discuss the availability of and the accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of health, the department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.*
   Response: Adequate professional and support staff will continue to be available and accessible to provide the services needed to the agency. The field staff availability will not change and will have better accessibility to the administrative staff with the relocation of the principle office from Covington, Tipton County to Brownsville, Haywood County. The elimination of two staff members with the result of closing the Covington location will reduce operating cost and streamline operations for better delivery of service to the certified area. The staff is currently and will remain with this project proposal in accordance with the standards of the Department of Health for Home Health Agencies.

5. *Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping, and staff education.*
Response: See attached agency policies addressing each of the requested licensing certification requirements.

6. *Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).*
Response: See attached Agency policies on the Student Preceptor Program. The Agency has no current contracts with facilities at this time but has accepted students in the past from Jackson State Community College and Dyersburg State Community College for preceptoring of RN and LPTA students for home health rotations.

7. *a. Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.*
Response: Please see attached policy from the Agency's Policy and Procedure Manual on Regulatory Requirements.

b. Please provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.
Licensure: ***Response:*** State of Tennessee, Department of Health, Board of Licensing Health Care Facilities.
Certification: ***Response:*** Professional Home Health Care, LLC has Medicare and Medicaid certification.
Accreditation: ***Response:*** Professional Home Health Care, LLC has no accreditation.

c. If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.
Response: See attached copy of the current facility license. Also see attached the current revalidation certification from Medicare and Medicaid.

d. For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.
Response: Please see the attached copy of the most recent licensure/certification inspection with the approved plan of correction.

8. *Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.*
Response: No final orders or judgments entered against professional licenses held by the applicant or any entity or persons with more than 5% ownership interest in this applicant.

9. *Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project.*
   Response: No final civil or criminal judgments for fraud or theft against any person or entity with more than 5% ownership interest in this project.

10. *If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and or other data as required.*
    Response: The agency will provide the JAR data annually which will include the number of patients treated, and the number and type of visits performed. The Agency will provide any requested data from the Tennessee Health Services and Development Agency.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

DEVELOPMENT SCHEDULE

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**
2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph,* please state below any request for an extended schedule and document the "good cause" for such an extension.**

Form HF0004
Revised 02/01/06
Previous Forms are obsolete

County: Madison
Printed In: Jackson Sun, The
Printed On: 2013/12/09

0101703740 NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that: Professional Home Health Care, LLC D/B/a CareAll Homecare Home Health Agency owned by: CareAll, LLC with an ownership type of a Limited Liability Company and to be managed by: CareAll Management, LLC intends to file an application for a Certificate of Need for: The relocation of its principle office from 901 Highway 51 South, Covington, Tipton County, Tennessee to the current location of its Brownsville branch office, 1151 Tammbell Street, Brownsville, Haywood County, Tennessee. Professional Home Health Care, LLC is licensed to serve Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lauderdale, McNairy, Madison, Obion, Tipton, and Weakley counties. Existing home care services will not be effected, and no service will be initiated or discontinued. The project does not impact patient care, involves no construction or capital expenditure or the acquisition or modification of any item of major medical equipment. Anticipated cost $59,300. The anticipated date of filing the application is: December 13, 2013. The contact person for the project is Mary Ellen Foley, Project Director who may be reached at: CareAll Management, LLC, 326 Welch Road, Nashville, Tennessee, 37211. 615-331-6137. Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to: Health Services and Development Agency Andrew Jackson Building, 9th Floor 502 Deaderick Street Nashville, TN 37243 The published Letter of Intent must contain the following statement pursuant to TCA Sec. 68-11-1607(c)(1): (A) any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled, and (B) any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Public Notice ID: 20856198

(a5)

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in T.C.A. § 68-11-1609(c): _____

Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

Phase	DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1. Architectural and engineering contract signed	NA	NA
2. Construction documents approved by the Tennessee Department of Health	NA	NA
3. Construction contract signed	NA	NA
4. Building permit secured	NA	NA
5. Site preparation completed	NA	NA
6. Building construction commenced	NA	NA
7. Construction 40% complete	NA	NA
8. Construction 80% complete	NA	NA
9. Construction 100% complete (approved for occupancy	NA	NA
10. *Issuance of license	NA	01/22/2012
11. *Initiation of service	NA	CURRENT
12. Final Architectural Certification of Payment	NA	NA
13. Final Project Report Form (HF0055)		

* **For projects that do NOT involve construction or renovation; Please complete items 10 and 11 only.**

Note: **If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.**

DEC 19'13 AM10:01

AFFIDAVIT

STATE OF Tennessee

COUNTY OF Weakley

Mary Ellen Foley, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

Mary Ellen Foley
SIGNATURE/TITLE

Sworn to and subscribed before me this 12th day of December (Month) 2013 (Year) a Notary Public in and for the County/State of Tammy Marie Hazlewood

Tammy Marie Hazlewood
NOTARY PUBLIC

My commission expires May 24, 2017 (Month/Day) (Year)

TAMMY MARIE HAZLEWOOD
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF WEAKLEY
My Commission Expires May 24, 2017

Attachment Section A; Application Profile, item 3
Corporate Charter and
Certificate of Corporate Existence

Section A, Item 3
Applicant Profile

DEC 18 8 48 65

State of Tennessee

Department of State

Certificate

The undersigned, as Secretary of State of the State of Tennessee, hereby certifies that the attached document was received for filing on behalf of

TIPTON COUNTY HOME HEALTH CARE, INC.

was duly executed in accordance with the Tennessee General Corporation Act, was found to conform to law and was filed by the undersigned, as Secretary of State, on the date noted on the document.

Therefore, the undersigned, as Secretary of State, and by virtue of the authority vested in him by law, hereby issues this certificate and attaches hereto the document which was duly filed on April 9th, 19 86.

Gentry Crowell
Secretary of State
by Ruth Cobb

SS-4404

SECRETARY
1986 APR -9 PM 1:14

C H A R T E R

O F

TIPTON COUNTY HOME HEALTH CARE, INC.

The undersigned natural person, having capacity to contract and acting as the incorporator of a corporation under the Tennessee General Corporation Act, adopts the following charter for such corporation:

1. The name of the corporation is:

Tipton County Home Health Care, Inc.

2. The duration of the corporation is perpetual.

3. The address of the principal office of the corporation in the State of Tennessee shall be 132 East Pleasant, Covington, Tipton County, Tennessee 38019.

4. The corporation is for profit.

5. The principal purpose for which the corporation is organized is to engage in the business of operating a home health care agency. In addition, this corporation may engage in any and all lawful businesses other than ones to which specific statutory provisions apply beyond the scope of the Tennessee General Corporation Act.

6. The maximum number of shares which the corporation shall have the authority to issue is two thousand (2,000) shares, each of which shall have a no par value.

7. The corporation will not commence business until consideration of an amount not less than One Thousand and No/100 ($1,000.00) Dollars has been received for the issuance of shares.

DATED this 9th day of April, 1986.

Douglas A. Brace, Incorporator

(30)

State of Tennessee

Department of State

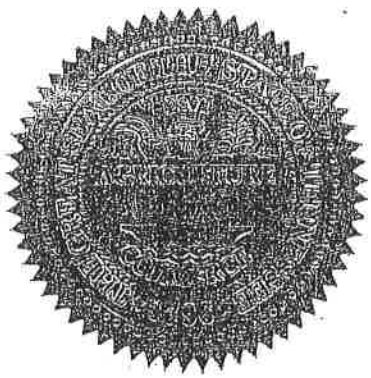
Certificate

The undersigned, as Secretary of State of the State of Tennessee, hereby certifies that the attached document was received for filing on behalf of

TIPTON COUNTY HOME HEALTH CARE, INC.
NAME CHANGED TO WEST TENNESSEE HOME HEALTH CARE, INC.

was duly executed in accordance with the Tennessee General Corporation Act, was found to conform to law and was filed by the undersigned, as Secretary of State, on the date noted on the document.

Therefore, the undersigned, as Secretary of State, and by virtue of the authority vested in him by law, hereby issues this certificate and attaches hereto the document which was duly filed on April 10th, 19 86.



Gentry Crowell
Secretary of State
by Leslie Cobb

SS-4404

(31)

ARTICLES OF AMENDMENT

TO THE CHARTER OF

TIPTON COUNTY HOME HEALTH CARE, INC.

Pursuant to the provisions of Section 48-1-303 of the Tennessee General Corporation Act, the undersigned corporation adopts the following Articles of Amendment to its Charter:

1. The name of the corporation is Tipton County Home Health Care, Inc.

2. The amendment adopted is changing the name of the corporation by deleting Paragraph 1 of the original Charter in its entirety and substituting in lieu thereof the following:

1. The name of the corporation is West Tennessee Home Health Care, Inc.

3. The amendment was duly adopted at a meeting of the incorporator as the sole director and shareholder of the corporation on April 10, 1986.

4. The amendment is to be effective when these Articles are filed by the Secretary of State.

DATED this 10th day of April, 1986.

TIPTON COUNTY HOME HEALTH CARE, INC.

BY: _____
Douglas A. Brace, Incorporator

State of Tennessee

Department of State

Certificate

The undersigned, as Secretary of State of the State of Tennessee, hereby certifies that the attached document was received for filing on behalf of

WEST TENNESSEE HOME HEALTH CARE, INC. NAME CHANGED TO PROFESSIONAL HOME HEALTH CARE, INC.

was duly executed in accordance with the Tennessee General Corporation Act, was found to conform to law and was filed by the undersigned, as Secretary of State, on the date noted on the document.

Therefore, the undersigned, as Secretary of State, and by virtue of the authority vested in him by law, hereby issues this certificate and attaches hereto the document which was duly filed on May 12th, 19 86.

Gentry Crowell
Secretary of State

by Carolyn Pinson

SS-4404

(33)

SECRETARY OF STATE

1986 MAY 12 PM 3:05

ARTICLES OF AMENDMENT

TO THE CHARTER OF

WEST TENNESSEE HOME HEALTH CARE, INC.

Pursuant to the provisions of Section 48-3-303 of the Tennessee General Corporation Act, the undersigned corporation adopts the following Articles of Amendment to its Charter:

1. The name of the corporation is West Tennessee Home Health Care, Inc.

2. The amendment adopted is changing the name of the corporation by deleting Paragraph 1 of the Articles of Amendment filed with the Secretary of State on April 10, 1986, in its entirety and substituting in lieu thereof the following:

1. The name of the corporation is Professional Home Health Care, Inc.

3. The amendment was duly adopted at a meeting of the incorporator as the sole director and shareholder of the corporation on May 9, 1986.

4. The amendment is to be effective when these Articles are filed by the Secretary of State.

DATED this 12th day of May, 1986.

WEST TENNESSEE HOME HEALTH CARE, INC.

BY: _____
Douglas A. Brace, Incorporator

STATE OF TENNESSEE, TIPTON COUNTY

I certify that this instrument was filed for registration on the 20 day Jan. 19 87 at 9:18 o'clock A M. entered in Entry Book 17, page 162, and RECORDED IN Book No. 3, Page No. 47.

Rec. Fee $ 25.00, State Tax $ —

Clk's Fee $ —, Receipt # 18761

Peggy Sain Register

(34)

170846

Attachment Section A: Applicant Profile, Item 4
Ownership structure of CareAll, Inc.

Section A, applicant Profile
Item 4

CareAll, Inc

Disclosure of Ownership

Master List

Name	Address	City	State	Zip	% of ownership
JWC Dynasty Trust	Equitable Trust Co 4400 Harding Rd Ste 310 Attn: Rick Travis	Nashville	TN	37205	71%
JWC Education Trust	Cumberland Trust 40 Burton Hills Blvd Ste 300 Attn: Jody Hines	Nashville	TN	37205	10%
JWC Evergreen Trust	Equitable Trust Co 4400 Harding Rd Ste 310 Attn: Rick Travis	Nashville	TN	37205	5%
Estate of James W. Carell	1066 Vaughn Crest Rd.	Franklin	TN	37069	13%
James M. Carell	741 Ligon Rd	Lebanon	TN	37090	1%

Attachment Section A: Applicant Profile, item 5

Management Agreement

Section A, Item 5
Applicant Profile

AMENDED AND RESTATED SERVICE AGREEMENT

THIS SERVICE AGREEMENT effective the 1st day of July 2006, by and between Professional Home Health Care, Inc. (the "Agency") and CareAll Management, Inc., ("CMI").

WITNESSETH:

WHEREAS, Agency is duly licensed in the State of Tennessee and operating a home health care agency; and

WHEREAS, CMI is engaged in the business of providing services to health care facilities; and

WHEREAS, Agency considers it to be in its best interest to engage the services of CMI; and

WHEREAS, The party currently entered into a Services Agreement dated January 28, 2005 which shall be amended and restated in accordance with the terms and conditions of this Amended and Restated Service Agreement.

NOW, THEREFORE, in consideration of the mutual promises and covenants herein contained, Agency and CMI agree as follows:

1. **Rights, Powers and Responsibilities.**

   a. Agency hereby retains CMI exclusively to provide the services specified herein for Agency during the term of this Agreement.

   b. Agency and CMI agree that Agency shall retain final authority with respect to all professional and ethical affairs of the Agency, all fiscal affairs of Agency, all general operating policies and all other aspects of the operation of Agency, except as are specifically delegated to CMI herein.

   c. CMI shall, with Agency's approval, have the right to consent, in the name of Agency through appropriate legal proceedings, the validity of application of any law, ordinance, ruling, regulation or requirement of any governmental agency having jurisdiction over Agency. Agency shall cooperate with CMI with regard to the contest and Agency shall pay any reasonable attorney's fees incurred with regard to such action. Counsel for the contest shall be selected by CMI with approval.

   d. CMI shall have the obligation to process all third part claims for services rendered, including the right to contest adjustments and denials by third-party payers (or their agents), without requiring written consent of Agency.

2. **Services.**

During the term of this Agreement, CMI shall, subject to Section 1 herein, provide the services set forth in Attachment A, Schedules 1 through 4, attached hereto and incorporated herein by reference.

3. **Access to Records and Facilities.**

Such books and records, as are maintained by CMI for the purpose of providing services under this Agreement, shall be made available, upon request, to Agency, its agents, accountants and attorneys, or upon receipt of a properly executed request, any representative of the Secretary of Health & Human Services of Comptroller General of the United States, during normal business hours. CMI shall respond to any questions of Agency concerning the books and records and shall assist Agency's auditors in the conduct of an audit of Agency's annual financial statements. CMI agrees to retain said books and records for a period of four (4) years after the settlement date for each year's Medicare cost report.

4. **Accreditation and License.**

a. CMI shall employ its best efforts to manage Agency in such a manner as will ensure that all necessary licenses, permits, consents and approvals from all government agencies have jurisdiction over Agency's operations are obtained and in compliance.

b. Neither Agency nor CMI shall knowingly or purposefully take any action which shall:

(1) Cause any government authority having jurisdiction over the operation of Agency to institute any proceeding(s) for the rescission or revocation of any necessary license, permit, consent or approval, or

(2) Adversely affect Agency's right to obtain and accept payments under Title XVIII of the Social Security Act, or any other public or private program for payment for medical services rendered.

5. **Use of CMI's Personnel and Services.**

CMI's staff specialists in such areas as accounting, auditing, budgeting, personnel, billing systems, clinical expertise, medical/utilization review, and third-party payments for home care services shall be actively utilized by Agency in the day-to-day operation of Agency when considered desirable by CMI or upon the reasonable request of Agency.

6. **Special Projects.**

CMI may, from time to time, engage consultants or teams of consultants, to perform projects in regard to services other than those stipulated in this Agreement, where such projects can be construed as contributing to improved operations of Agency, and their fees shall be paid by Agency. Such consultants may not be engaged, without approval of Agency, in the event that their fees, charges and expenses in connection with the contemplated assignment could reasonably be expected to exceed One Thousand and No/100 ($1,000.00) Dollars.

7. **Agency's Representative.**

Agency hereby appoints its president, or his or her designee, as its authorized representative to take any action necessary to enable CMI to act on Agency's behalf pursuant to this Agreement, including without limitation the authority to grant any necessary approvals or consents, and to receive any reports or other documents to be provided by CMI under this Agreement.

8. **Term.**

The term of this Agreement shall be for a period commencing on July 1, 2006 and ending on December 31, 2009.

9. **Event of Default – Termination by CMI.**

CMI may terminate this Agreement if Agency shall fail to keep, observe or perform any material covenant, agreement, term or provision of the Agreement to be kept, observed or performed by Agency and such default shall continue for a period of thirty (30) days after notice thereof by CMI to Agency.

10. **Event of Default – Termination by Agency.**

a. Any of the following shall be an event of default hereunder on the part of CMI:

(1) If CMI shall fail to keep, observe, pay or perform any convenient obligation, agreement, term or provision of this Agreement to be kept, observed, paid or performed by CMI and such default shall continue for a period of sixty (60) days after notice thereof by Agency to CMI.

(2) If any license necessary or desirable for the operation of Agency is at anytime suspended, terminated or revoked, and such suspension, termination or revocation shall continue unstayed and in effect for a period of forty-five (45) days consecutively.

b. If the event of default shall be failure to make payment as provided in this Agreement, Agency shall, in addition to recovery of the amount paid, be entitled to reasonable attorney's fees and costs of collection.

11. **Management Fees.**

a. During the term of this Agreement, CMI shall be compensated for services rendered in accordance with fee schedules set forth in Attachment B, attached hereto and incorporated herein by reference.

b. CMI shall invoice Agency for services rendered on or by the tenth (10^{th}) day of the month.

c. Agency agrees to pay CMI the monthly late fee in the amount equal to one and one – half percent (1½%) of any payment due CMI which is not paid within ninety (90) days of the original invoice date.

d. The Agencies president shall approve the payment of all management fees.

12. **Non-assumption of Liabilities.**

CMI shall not, by entering into and performing this Agreement, become liable for any of the existing or future obligations, liabilities or debts of Agency, and will in its role as CMI have only the obligations to exercise reasonable care in its management and handling of the funds generated from the operation of Agency.

13. **Notices.**

All notices hereunder by either party to the other shall be in writing. All notices, demands and requests shall be deemed given when mailed, postage prepaid, registered or certified mail:

a. to Agency at:

b. to CMI at: 4015 Travis Drive, Suite 200
Nashville, TN 37211

or to such other address, or to such other person who may be designated by notice given from time to time during the term of this agreement by one party to the other.

14. **Assignability.**

This Agreement may be assigned by either party and shall be binding upon its assigns and successors in interest.

15. **Entire Agreement.**

This Agreement contains the entire agreement between the parties hereto, and no representation or agreement, oral or otherwise, between the parties not embodied herein or attached hereto shall be of any force and effect. Any additions or amendments to this Agreement subsequent hereto shall be of no force and effect unless in writing and signed by the parties hereto.

16. **Governing Law.**

This Agreement has been executed and delivered in the State of Tennessee and all of the terms and provisions hereof and the rights and obligations of the parties hereto shall be construed and enforced in accordance with the laws thereof.

17. **Captions and Headings.**

The captions and headings throughout this Agreement are for convenience and reference only, and the words contained therein shall in no way be held or deemed to define, limit, describe, explain, modify, amplify or add to the interpretation, construction, or meaning of any provision of this or the scope or intent of this Agreement nor in any way affect the Agreement.

18. **Impossibility of Performance.**

CMI shall not be deemed to be in violation of this Agreement if it is prevented, either directly or indirectly, from performing any of its obligations hereunder for any reason beyond its control, including without limitation, allowable Medicare funding, acts of God or the public enemy, flood or storm strikes, or statutory regulation or rule of any federal, state or local government, or any agency thereof.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year first above written.

"AGENCY" **Professional Home Health Care, Inc.**

BY: Brenda Dunn, R.N.
Brenda Dunn, President

"CMI" **CareAll Management, Inc.**

BY: J.W. Carell
J.W. Carell, President

F:\DAB\CARELL\ 2006 Service Agreement - ProfessionalHomeHealthCare.doc
7/25/06

ATTACHMENT A

SERVICES TO BE PROVIDED BY CMI

Schedule 1: Reimbursement Services

a. CMI shall arrange for the preparation of Agency's annual Medicare cost report.

b. CMI shall continuously review and monitor the setting of payment rates, calculate where necessary and submit such computations to the fiscal intermediary as required. CMI shall prepare, or cause to be prepared, the appropriate reports, if any, to be filed with the fiscal intermediary.

c. CMI shall negotiate on behalf of Agency, unless Agency chooses to conduct such negotiations, any repayment schedules necessary in the event Agency is overpaid by third-party payers and lacks sufficient funds for immediate repayment.

d. CMI shall regularly analyze Agency's visit statistics and mix of visits in relation to the prospective pay system to ensure optimum use of staffing and financial resources.

e. CMI shall conduct on behalf of Agency, unless Agency chooses to conduct such negotiations, any formal and/or informal appellate proceedings in regard to reasonableness determinations made by the fiscal intermediary in regard to the Agency's Medicare cost report. Said proceedings may be pursued to the Provider Reimbursement Review Board level. Beyond this level, appellate proceedings must have the approval of Agency and this shall also mean that the expenses associated with proceedings after the Provider Reimbursement Review Board shall be borne by Agency.

f. CMI shall perform, on a periodic basis, special studies to ensure that Agency is taking advantage of every available option, election and alternative with which to legitimately maximize the amount of reimbursement received from third-party payor in accordance with applicable law and regulation.

g. CMI may conduct all dealings with local representatives of the fiscal intermediary, including, but not limited to, the following:

(1) Entrance and exist conferences;
(2) Repayment schedule;
(3) Administrative reviews;
(4) Appeal procedure up to the Provider Reimbursement Review Board stage; and
(5) Administrative Law Judge hearings.

h. CMI shall handle all dealings on behalf of Agency, unless Agency chooses to conduct such dealings, with representatives of respective government agencies concerned with the administration of Title XVIII of the Social Security Act.

i. CMI shall advise Agency on a regular basis of developments, legislative and otherwise, which may affect the operations of Agency, e.g., certificate of need regulations, prospective reimbursement and National Health Insurance.

j. CMI shall be responsible for collection and disbursement of all funds or monies, Medicare, Medicaid received by Agency and maintain books and records in accordance with generally accepted accounting principles.

k. All funds received or generated by Agency operations, shall be deposited by CMI in a bank account(s) as designated by Agency. Said accounts are defined as operating accounts, in the name of Agency, out of which shall be disbursed all costs and expenses relative to the operation of Agency. CMI shall periodically review Agency's working capital needs to ensure Agency remains financially viable at all times. Any and all checks or documents of withdrawal from the operating accounts may be signed by CMI.

Schedule 2: Clinical/Operational Consulting Services

a. CMI shall prepare and deliver a quarterly status report of the affairs of Agency with specific commentary on the number of visits, personnel status and current events and/or developments impacting Agency's operations, within thirty (30) days of the preceding calendar quarter to which the status report relates.

b. CMI shall prepare and deliver an annual report describing the operations, policies and problems with respect to Agency covering in reasonable detail all aspects of Agency. This report shall be delivered to Agency within sixty (60) days of the preceding year or twelve (12) month period to which the report relates.

c. CMI shall prepare and deliver such other reports as are reasonable, from time to time, requested by Agency with regard to comparisons of Agency to similar agencies and analysis of the relative efficiency of Agency's various services.

d. CMI shall interview for the position of Agency Administrator and make recommendation to Agency Owner based on interviewee's qualifications. All other positions in Agency shall be hired by Agency Administrative or his or her designee.

e. CMI shall periodically review the job related educational needs of Agency employees and shall schedule, organize and/or conduct such internal and/or external training programs and seminars as often as CMI deems necessary, or at the request of Agency for such training programs and seminars, to meet performance requirements for Agency employees.

f. CMI shall prepare and submit for Agency's approval, or review and revise, a personnel policy and Agency policies and procedure manual. The personnel manual shall contain job descriptions for all categories of the Agency staff, general personnel policies and wage and salary scales. Proposals for adjustments to the wage and salary scales, whether necessitated by law or equity, shall be periodically submitted to Agency for its study and recommendations.

g. CMI shall provide clinical professional staff at Agency expense, to ensure the documentation, quality assurance, and state/federal guidelines are being met. CMI will provide personnel to perform quality assurance duties on a time and direct expense, travel, lodging and materials basis.

(1) Reviewing and screening of all forms, patient visit summaries for Medicare and Medicaid before billing process occurs.

(2) Develop and implement Quality Assurance program to ensure that quality care is being delivered to the patient.

(i) Chart audits (5% sampling)
(ii) Patient questionnaire/Physician questionnaire
(iii) Continuing Utilization review
(iv) Assist with annual evaluation

(3) In-service educational updates on a monthly basis for all supervisory staff.

(5) Claims management with intermediaries for all denials and requested information on claims.

(5) On-site review of all clinical procedures on an equal basis to ensure Agency compliance to state/federal guidelines.

(6) CMI shall maintain and, where possible, improve or upgrade Agency standards and procedures for admitting patients, and for collecting revenues from patients and/or third party payers. CMI shall implement collection activities and shall ensure uniformity of charges to patients, regardless of his/her mode of payment.

h. CMI shall recommend and implement, subject to Agency's approval, appropriate employee benefit programs. Employee benefits are defined as those benefits insuring to employees, such as pension plans, health and life insurance benefits, worker's compensation incentive plans for key employees, vacations and holidays.

i. CMI shall make, at least semi-annually, evaluations of the performance of all administrative and professional services of Agency.

j. CMI shall establish and maintain an ongoing community relations program designed to assist the public with interpretation of Agency's services and to foster good working relations with physicians and other providers within the health care community.

k. CMI shall represent Agency at meetings, conventions, seminars, and workshops related to the home health care field and/or specifically to Agency, both on a local and national basis.

Schedule 3: Accounts Receivable/Billing/Purchasing/Computer Services

a. CMI shall provide preparation, billing and collection of patient accounts. CMI shall take all reasonable steps to ensure that all claims related to the production of revenue are processed on a timely basis, and in the format prescribed by servicing intermediaries. CMI shall, institute on-line processing of claims, ADR's, etc., progressing to a totally paperless process.

b. CMI shall enforce the rights of Agency as a creditor under any contract or for the performance of any services, act as full power with the agency intermediary for billing information, or correspondence to operate Agency.

c. CMI shall purchase, in accordance with approved purchasing policies, such medical supplies, solutions, equipment and vehicles (including leasing thereof), furniture, furnishings, materials and services (including service and maintenance contract) which are deemed necessary to the efficient operation of Agency. Purchases, single or cumulative, in excess of Five Thousand and No/100 ($5,000.00) Dollars will require approval of an officer or designee of Agency.

d. CMI shall take all responsible steps to assure orderly and prompt payment of bills, accounts payable, employee payroll taxes, general taxes levied on Agency and insurance premiums of Agency. CMI's responsibility under this section shall be limited to the exercise of due care and reasonable diligence to apply funds collected in the operation of Agency in a timely and prudent manner. CMI does not assume the financial obligation for funding the payment of debts.

e. CMI shall have the authority to arrange for lease equipment when it appears to be in the best interest of Agency and Agency shall have the final approval of such contracts.

Schedule 4: Accounting Services

a. CMI shall maintain an adequate chart of account, accounting systems, internal controls and such other accounting and statistical data gathering systems as are necessary to comply with applicable law and regulations.

b. CMI shall ensure that proper inventories of all of Agency's fixed and current assets are maintained on a current basis and that adequate controls are exercised to maintain the security of Agency's assets.

c. CMI shall establish and maintain an internal cost containment program designed to stimulate employee interest in controlling cost wherever practicable and to promote employee awareness of the need to contain costs through proper procedure, work methods and adherence to Agency's established policies.

d. CMI shall prepare and process the bi-weekly Agency payroll. Prepare and file all reports required by state and federal guidelines; quarterly state unemployment reports, 941's, 940's, W-2's, W-3's and 1099's.

e. CMI shall prepare and deliver monthly financial statements containing a balance sheet and statement of income in conventional detail, within thirty (30) days after the end of the preceding calendar month to which the financial statement relates.

f. Not later than thirty (30) days prior to the commencement of each fiscal year, CMI shall prepare and deliver to Agency with respect to the following fiscal year:

(1) A capital expenditure budget outlining a program of capital expenditures for the next fiscal year. This budget shall designate proposed expenditures as either mandatory, desirable or optional;

(2) An operating budget setting forth an estimate of operating revenues and expenses for the next fiscal year. The budget shall be in conventional detail and shall contain narrative explanations of changes in utilization, rates, payroll and other factors differing significantly from the current year; and

(3) A projection of cash receipts and disbursements based upon the capital and operating budgets. This projection shall contain recommendations concerning the utilization of funds generated by excess cash flow or the need for temporary borrower where negative cash flow is anticipated.

ATTACHMENT B TO SERVICE AGREEMENT

1. GENERAL MANAGEMENT FEES.

a. Home Health – 7% of Gross Revenues for each patient episodic period based upon gross revenues for the month preceding each monthly billing date.

b. CDD Private Duty – 15% of Gross Revenue less staffing wages

2. OASIS (OUTCOMES AND ASSESMENT INFORMATION SET). CMI shall develop and implement a program to assure the Oasis collection mandate is being achieved and Agency shall pay CMI for keying and processing OASIS sets as follows:

Start of Care Set - $50 per set
Follow Up Set - $25 per set
Transfer Set - $15 per set
Discharge Set - $25 per set

3. PRE-CERTIFICATION FEES.

a. $175 per new pre-certification episode
b. $87.50 per carryover episode

4. HHRG NURSE CONSULTING. $90 per hour

5. ON SITE SERVICES. In the event that Agency requests that CMI personnel perform services for Agency on site, Agency agrees to pay CMI the following discounted hourly rates:

Classification	Hourly Rate
Chief Operating Officer/President	$ 150.00
Chief Financial Officer	125.00
Audit/Compliance Specialist	100.00
Reimbursement Specialist	100.00
Professional Support Specialist	100.00
Administrative Assistant	53.30
ADRs	249.50 per request
Pre-Certification	175.00 per request
Episodic Carryover	87.50

Travel expense $.36 per mile, in addition to lodging and food.

Note: If the total fees received by CMI pursuant to items 1-5, above, create an after tax profit for CMI in excess of 20%, CMI shall refund to Agency Owner such fees in an amount necessary to reduce CMI's after tax profit to 20%, as calculated on an annual basis.

FIRST AMENDMENT
TO AMENDED AND RESTATED SERVICE AGREEMENT
(Professional Home Health Care, Inc.)

THIS FIRST AMENDMENT TO AMENDED AND RESTATED SERVICE AGREEMENT is made as of the 1st day of September, 2008 by and among **Professional Home Health Care, Inc.** (the **"Agency"**), **CareAll Management, LLC, formerly CareAll Management, Inc.** (**"CMI"**), and **James W. Carell** (**"Carell"**).

W I T N E S S E T H:

WHEREAS, Agency and CMI entered into an Amended and Restated Service Agreement dated July 1, 2006 pertaining to certain services to be provided by CMI for the Agency (the **"Service Agreement"**); and

WHEREAS, Attachment "B" to the Amended and Restated Service Agreement outlined the method for compensation of CMI which was never implemented; and

WHEREAS, to accurately reflect the compensation of the parties performing services under the Amended and Restated Service Agreement and Carell as President and Director of the Agency, the parties desire to substitute a new Attachment "B" to be effective ***ab initio***.

NOW, THEREFORE, for and consideration of these mutual premises and other considerations, the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree to delete existing Attachment "B" and substitute in lieu thereof Attachment "B" attached hereto to be effective ***ab initio*** from the date of the Amended and Restated Service Agreement.

All other terms and conditions of the Amended and Restated Service Agreement not otherwise modified or changed herein, remain in full force and effect.

IN WITNESS WHEREOF, the undersigned have executed this First Amendment to Amended and Restated Service Agreement as of the day and year first above written.

CareAll Management, LLC

By: _____
James W. Carell, Chief Manager/President

Professional Home Health Care, Inc.

By: _____
James W. Carell, Chief Manager/President

_____
James W. Carell

F:\DAB\CARELL\CareAll Management\1st Amendment to Service Agreement (PHH).doc

ATTACHMENT "B"
TO AMENDED AND RESTATED SERVICE AGREEMENT
(September 1, 2008)

1. **Compensation to CMI:**

(a) Home Health Care. Agency shall pay CMI seven percent ~~(7%)~~ 6% of its gross revenues generated from its home health care operations, payable monthly, on or before the 15th of each month based upon the preceding month's billing.

(b) Private Duty Care. Agency shall pay CMI twenty percent ~~(20%)~~ 15% of its gross revenues generated from its private duty care operations, less Employee expenses, payable monthly, on or before the 15th of each month based upon the preceding month's billing.

2. **Compensation to Carell:**

(a) Home Health Care. Agency shall pay Carell twenty four percent (24%) of its gross revenues generated from its home health care operations, payable monthly, on or before the 15th of each month based upon the preceding month's billing.

(b) Private Duty Care. Agency shall pay Carell five percent (5%) of its gross revenues generated from its private duty care operations, less Employee expenses, payable monthly, on or before the 15th of each month based upon the preceding month's billing.

Agency: _____

CMI: _____

Attachment Section A: Applicant Profile, Item 6
Lease agreement

LEASE

THIS LEASE IS MADE AND ENTERED into on this 18th day of November, 2013 by and between D.C. Construction & Trucking, Inc., hereinafter referred to as the Lessor, and CareAll Home Care Service of BROWNSVILLE a subsidiary of Professional Heath Care, Inc., hereinafter referred to as Lessee,

WITNESSETH:

The Lessor have leased to the Lessee, and the Lessee has leased from the Lessor the north one-third of a building at the northeast corner of North Washington and Tambell Streets, Brownsville, 7th Civil District, Haywood County, Tennessee, the address being 1151 Tambell, Brownsville, Tennessee. The parties mutually agree to the following terms and conditions:

1. The term of this lease will be for a period of Three (3) years commencing December 1st, 2013, and terminating November 30th, 2016.
2. The Lessee shall continue to pay rent to the Lessor the sum of $1,300.00, One thousand three hundred dollars and 00/100 per month.
3. The Lessee covenants and agrees that said premises shall be used and occupied in a safe and careful manner and that no waste shall be committed thereon nor any damage done to said property.
4. The Lessee agrees not to make any additions, alterations or improvements to the property without the written consent of the Lessor, and any additions, improvements or alterations made by the Lessee shall be and remain the property of the Lessor provided that all fixtures not permanently attached to the building by the Lessee shall remain the property of the Lessee, and shall be removable by the Lessee at the expiration of this lease.
5. The Lessee agrees to deliver up to the Lessor the premises at the expiration of this lease in good order and condition, usual wear and tear expected.
6. The Lessee covenants and agrees not to sub-let the premises without the written consent of the Lessor.
7. If the Lessee defaults in the payment of rent or defaults in other conditions of this agreement, the Lessor shall have the option of declaring this lease terminated and shall have the right to make demand and collect from the Lessee the entire unpaid balance for the lease period.
8. The Lessor shall provide adequate casualty insurance coverage on the building, and the Lessee will be responsible for any insurance on its contents.
9. The Lessor shall be responsible for any repairs to the roof, outside walls, and foundation, and the Lessee will be responsible for any minor repairs on the interior.
10. The Lessee shall be responsible for payment of any yard cutting, trimming shrubs, pest control, and utilities (including: gas, water, sewer, electricity, and trash pickup).
11. The Lessee agrees to hold the Lessor harmless against all claims and causes of action caused by the negligence of the Lessee or its agents and employees.
12. If it becomes necessary for either party to this lease to employ an attorney or to institute court action, the losing party agrees to pay the reasonable attorney's fee of the other party and all court costs.
13. This lease contains the entire agreement between the parties, and no representations, promises and agreements between the parties not set out herein shall be of any force or effect.
14. This lease is binding on the parties, their heirs, its successors and assigns and personal representatives.

WITNESS OUR SIGNATURES on the date first above mentioned.

D.C. CONSTRUCTION & TRUCKING, INC.
DAVID COULSTON
LESSOR

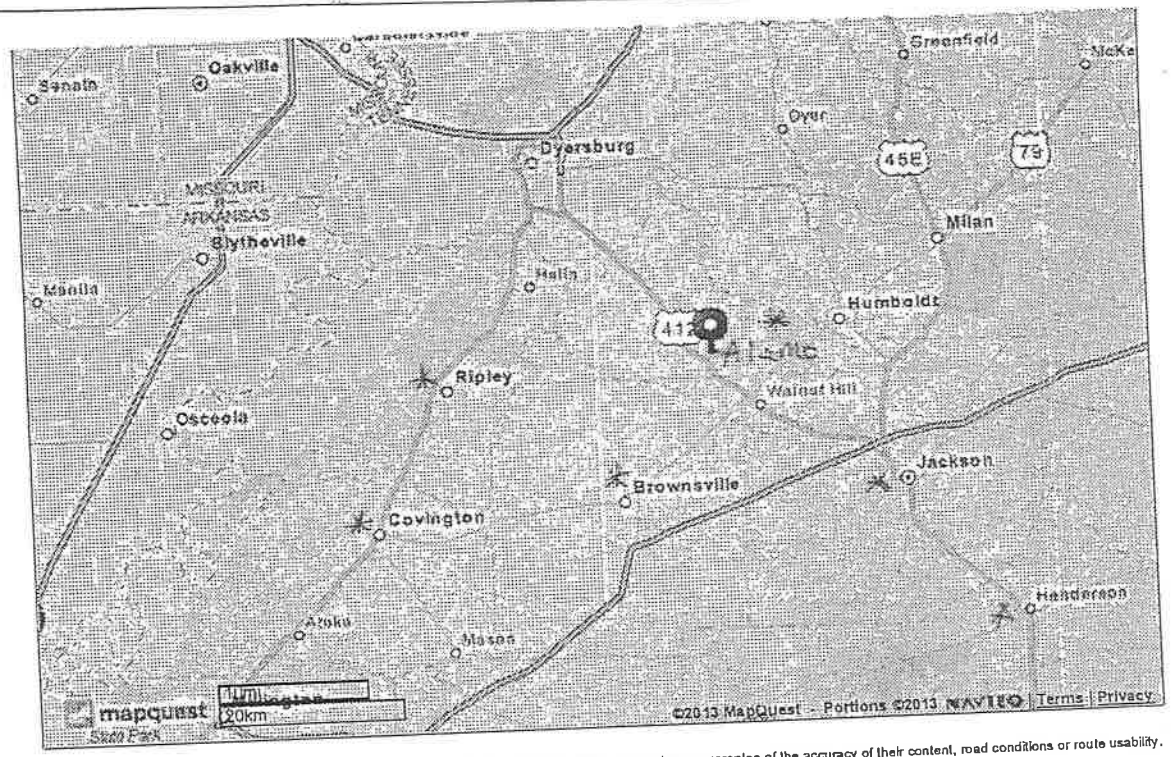
Professional Health Care, Inc.

BY _____ 11/20/13
LESSEE

Attachment Section B, Project Description

Item 1

(54)



Current offices

Ripley
Alamo
Jackson
Henderson
Brownsville
Covington

Attachment, Section B Project description, Item 2.D
CMS proposed payment changes
for Medicare Home Health Agencies

Section B, Item 2. D

CMS.gov
Centers for Medicare & Medicaid Services

Details for Title: CMS PROPOSES PAYMENT CHANGES FOR MEDICARE HOME HEALTH AGENCIES FOR 2014

Title	CMS PROPOSES PAYMENT CHANGES FOR MEDICARE HOME HEALTH AGENCIES FOR 2014
For Immediate Release	Thursday, June 27, 2013
Contact	press@cms.hhs.gov

CMS PROPOSES PAYMENT CHANGES FOR MEDICARE HOME HEALTH AGENCIES FOR 2014

The Centers for Medicare & Medicaid Services (CMS) today announced proposed changes to the Medicare home health prospective payment system (HH PPS) for calendar year (CY) 2014 that would foster greater efficiency, flexibility, payment accuracy, and improved quality. Based on the most recent data available, CMS estimates that approximately 3.5 million beneficiaries received home health services from nearly 12,000 home health agencies, costing Medicare approximately $18.2 billion in 2012.

In the rule, CMS projects that Medicare payments to home health agencies in calendar year (CY) 2014 will be reduced by 1.5 percent, or $290 million based on the proposed policies. The proposed decrease reflects the effects of the 2.4 percent home health payment update percentage ($460 million increase), the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and the non-routine medical supplies (NRS) conversion factor ($650 million decrease), and the effects of ICD-9-CM coding adjustments ($100 million decrease).

In addition, the rule proposes routine updates to the HH PPS payment rates such as updating the payment rates by the HH PPS payment update percentage and updating the home health wage index for 2014.

Background

To qualify for the Medicare home health benefit, a Medicare beneficiary must be under the care of a physician, have an intermittent need for skilled nursing care, or need physical therapy, speech -language pathology, or continue to need occupational therapy. The beneficiary must be homebound and receive home health services from a Medicare approved home health agency (HHA).

Medicare pays home health agencies through a prospective payment system that pays higher rates for services furnished to beneficiaries with greater needs. Payment rates are based on relevant data from patient assessments conducted by clinicians as currently required for all Medicare-participating home health agencies. Home health payment rates are updated annually by the home health payment update percentage. The payment update percentage is based, in part, on the home health market basket, which measures inflation in the prices of an appropriate mix of goods and services included in home health services.

HH PPS Grouper Refinements and ICD-10-CM Conversion

The proposed rule would remove two categories of ICD-9-CM codes from the HH PPS Grouper: diagnosis codes that are "too acute," meaning the condition could not be appropriately cared for in a home health setting; and diagnosis codes for conditions that would not impact the home health plan of care, or would not result in additional resources when providing home health services to the beneficiary. ICD-10-CM codes will be included in the HH PPS Grouper to be used starting on October 1, 2014. The new ICD-10-CM codes will replace the existing ICD-9-CM codes used to report medical diagnoses and inpatient procedures.

Rebasing the 60-day Episode Rate

The Affordable Care Act requires that beginning in CY 2014, CMS apply an adjustment to the national standardized 60-day episode rate and other applicable amounts to reflect factors such as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other relevant factors. Additionally, CMS must phase-in any adjustment over a four year period, in equal increments, not to exceed 3.5 percent of the amount (or amounts) in any given year, and be fully implemented by CY 2017.

The rule proposes a reduction to the national, standardized 60-day episode rate of 3.5 percent in each year CY 2014 through CY 2017. The proposed national, standardized 60-day episode payment for CY 2014 is $2,860.20. This reduction primarily reflects the observed reduction in the number of visits per episode since establishment of the HH PPS in 2000.

(58)

Rebasing Per-Visit Amounts

For episodes with four or fewer visits, Medicare pays on the basis of a national per-visit amount by discipline, referred to as a Low-Utilization Payment Adjustment (LUPA). The rule proposes an increase to each of the per-visit payment rates of 3.5 percent in each year CY 2014 through CY 2017 to account for changes in the costs of providing these services since the establishment of the HH PPS in 2000.

Rebasing and Updating Other Components of the HH PPS

Similar to the proposals for rebasing 60-day episodes and per-visit rates, this proposed rule would rebase the payment for NRS and update the LUPA add-on payment amount. The rule proposes a decrease in the NRS conversion factor of 2.58 percent in each year CY 2014 through CY 2017. In updating the LUPA add-on amount and proposing three LUPA add-on factors, LUPA add-on payments are estimated to increase by approximately 4.8 percent (using rebased per-visit amounts described above that were increased by 3.5 percent).

Quality Reporting

The proposed rule would add two claims-based quality measures: (1) Rehospitalization During the First 30 Days of a Home Health Stay, and (2) Emergency Department Use Without Hospital Readmission during the first 30 days of Home Health. The proposed rehospitalization measures will allow HHAs to further target patients who entered home health after a hospitalization. In addition, this rule would reduce the number of home health quality measures currently reported to home health agencies to simplify their use for quality improvement activities.

Cost Allocations for Home Health Agency Surveys

This proposed rule would ensure that Medicaid responsibilities for home health surveys are explicitly recognized in the State Medicaid Plan. CMS seeks comment on a methodology for calculating State Medicaid programs' fair share of Home Health Agency surveys costs. For that portion of costs attributable to Medicare and Medicaid, we would assign 50 percent to Medicare and 50 percent to Medicaid, the same methodology that is used to allocate costs for dually-certified nursing homes.

For additional information about the Home Health Prospective Payment System, visit https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html.
The proposed rule can be viewed: http://federalregister.gov/inspection.aspx. Please be mindful this link will change once the proposed rule is published on July 3, 2013 in the Federal Register. CMS will accept comments on the proposed rule until August 26, 2013.

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(59)

Attachment section B, Project Description, Item 3, A.

Plot of the Site

Section 18, Item 3.H

(19)

DEC 13'13 AM10:04

Tamm Street

Professional
Home Health Care
DBA CareAll
2300 sqfeet

7500 square feet

1 acre

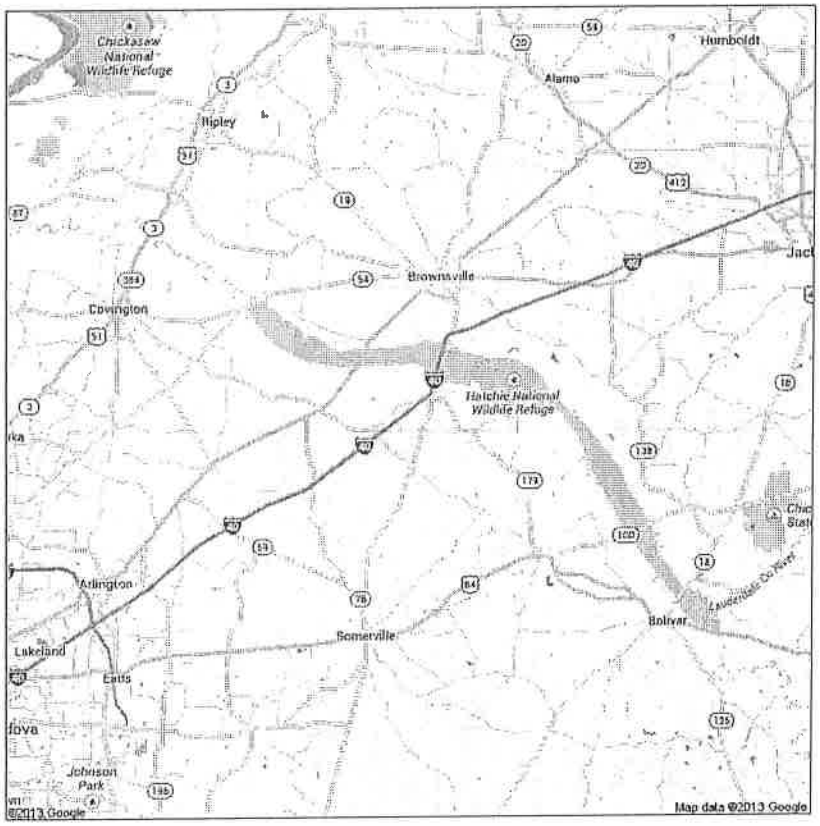
N. Washington Ave

Tamm Street

Attachment Section B, Project Description, Item3, B.

Google map of the area

Google



(63)

Attachment Section B, Project Description, Item 4

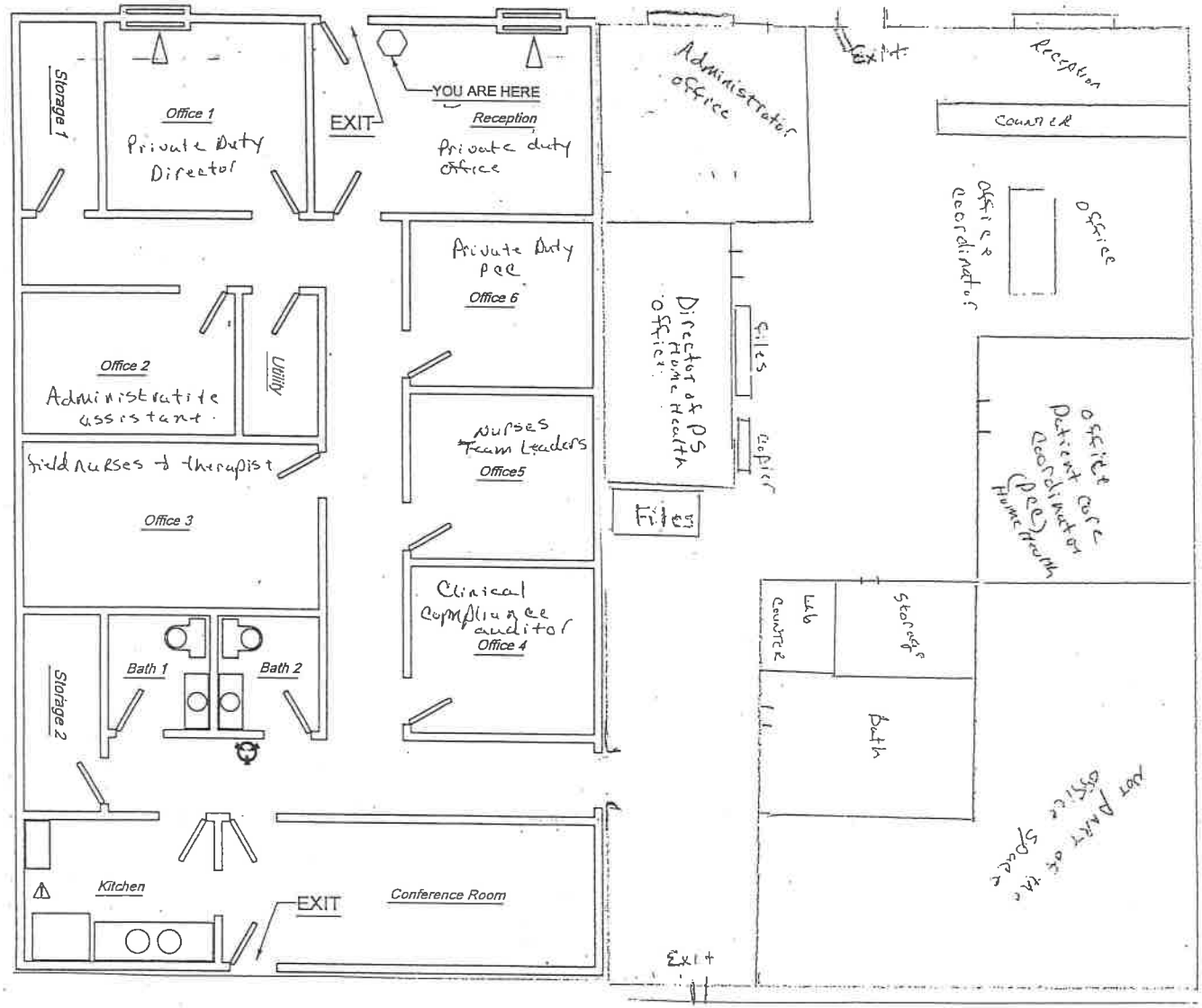
Floor Plan Drawing

1151 Tammbell Street
Brownsville, TN. 38012

(65)

Tammbell

Front



Attachment Section C, Need, Item 1, A.

Home Health Services Criteria

Section C, Need
Item 1, a.

HOME HEALTH SERVICES

1. The need for home health agencies/services shall be determined on a county by county basis.

2. In a given county, 1.5 percent of the total population will be considered as the need estimate for home health services in that county.

   The 1.5 percent formula will be applied as a general guideline, as a means of comparison within the proposed service area.

3. Using recognized population sources, projections for four years into the future will be used.

4. The use rate of existing home health agencies in the county will be determined by examining the latest utilization rate as calculated in the Joint Annual Report of existing home health agencies in the service area.

   Based on the number of patients served by home health agencies in the service area, an estimation will be made as to how many patients could be served in the future.

5. Documentation from referral sources:

   a. The applicant shall provide letters of intent from physicians and other referral sources pertaining to patient referral.

   b. The applicant shall provide information indicating the types of cases physicians would refer to the proposed home health agency and the projected number of cases by service category to be provided in the initial year of operation.

   c. The applicant shall provide letters from potential patients or providers in the proposed service area that state they have attempted to find appropriate home health services but have not been able to secure such services.

   d. The applicant shall provide information concerning whether a proposed agency would provide services different from those services offered by existing agencies.

6. The proposed charges shall be reasonable in comparison with those of other similar facilities in the service area or in adjoining service areas.

   a. The average cost per visit by service category shall be listed.

   b. The average cost per patient based upon the projected number of visits per patient shall be listed.

Attachment Section C, Need, Item 1 a.

Criteria #3, Home Health Services

Section C, Item 1a - Need
Criteria #3 from Home Health Services

(49)

2011 TN Res Population			
TN Res. Age Group	Patients	Population	Statewide Ratio
Ages 0 - 17	3,959	1,492,473	0.0027
Ages 18 - 64	44,945	4,031,086	0.0111
Ages 65 - 74	36,557	502,969	0.0727
Ages 75 +	86,346	376,612	0.2293
Total	171,807	6,403,140	0.0268

2010-2011 TN Res Population (Together)			
TN Res. Age Group	Patients	Population	Statewide Ratio
Ages 0 - 17	8,646	2,988,474	0.0029
Ages 18 - 64	89,781	8,027,728	0.0112
Ages 65 - 74	74,566	990,043	0.0753
Ages 75 +	166,944	743,000	0.2247
Total	339,937	12,749,245	0.0267

2010 TN Res Population			
TN Res. Age Group	Patients	Population	Statewide Ratio
Ages 0 - 17	4,687	1,496,001	0.0031
Ages 18 - 64	44,836	3,996,642	0.0112
Ages 65 - 74	38,009	487,074	0.0780
Ages 75 +	80,598	366,388	0.2200
Total	168,130	6,346,105	0.0265

Attachment Section C, Need, item 1 a.

Criteria #4 Home Health Services

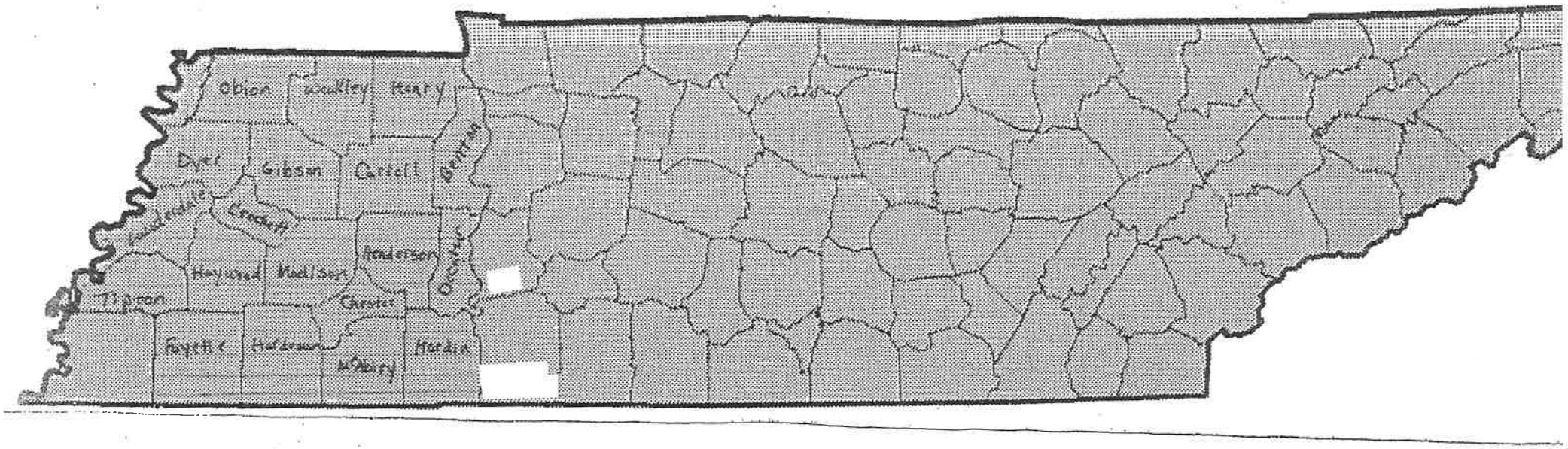
Section C, Item 1a. Criteria #4

Section C, Need, Item 5

County	Agency	current Patient	current visits	2012 Patients	2012 visits	2011 patients	2011 visits	2010 patients	2010 visits
Benton	Tennessee Quality HH-North West	1,164	31,200	1,128	35,809	1,129	34,708	1,129	34,708
Carroll	Baptist Memorial Hosp HH	262	4,365	213	4,563	235	4,483	245	4,686
Decatur	Tennessee Quality HH-South West	1,080	37,708	1,082	41,010	1,352	45,155	1,080	37,708
	Volunteer Home care	1,534	51,090	1,503	59,191	1,598	62,863	1,401	61,060
Dyer	Regional Homecare -Dyer	707	24,161	814	25,936	744	25,147	655	19,817
Fayette	NHC Homecare	226	8,535	217	9,043	254	10,899	254	12,060
	Where the heart IS	116	3,487	271	3,658	253	1,453	34	736
Gibson	NHC-Gibson	569	17,601	625	19,744	479	20,667	546	21,723
	Volunteer Homecare -Gibson	3,041	77,139	3,027	75,415	2,549	71,266	2,443	70,172
Hardin	Deaconess Homecare-Hardin	1,330	42,646	1,244	52,175	1,213	55,013	1,124	50,863
	HMC Home Health	341	10,437	274	10,151	252	10,550	308	12,379
Henderson	Regional Home Care-Lexington	569	21,853	616	25,069	578	23,948	683	26,690
Henry	Henry CountyMedical Center-HH	363	7,276	399	8,070	355	7,517	474	10,087
Madison	Amedisys HHC-Madison	2,741	93,572	2,586	85,497	2,489	87,882	2,407	87,880
	Extendicare HH of West Tenn	1,085	32,356	993	32,457	962	38,306	1,015	42,079
	Intrepid USA	422	17,257	86	2,763	294	8,013	210	7,381
	Medical Center Home health	1,706	36,648	1,617	42,307	1,403	44,333	1,329	39,860
	Regional Home care-Jackson	1,164	41,439	1,061	not recorded	1,206	44,628	969	32,423
Obion	Extendicare HH of WTN-Obion	302	8,245	347	10,600	398	16,888	499	20,902
Tipton	Baptist Memorial Hosp HH-Covington	353	5,281	361	5,959	326	4,491	330	4,601
Weakley	CareAll Home care -University HH	2,036	74,987	2,668	116,347	1,903	123,638	1,902	92,329

TN.gov JAR reports

Attachment Section C, Need, Item 3



Service area

Attachment Section C, Need, Item 5

Section C, Item 1a. Criteria #4

Section C, Need, Item 5

(75)

County	Agency	current Patient	current visits	2012 Patients	2012 visits	2011 patients	2011 visits	2010 patients	2010 visits
Benton	Tennessee Quality HH-North West	1,164	31,200	1,128	35,809	1,129	34,708	1,129	34,708
Carroll	Baptist Memorial Hosp HH	262	4,365	213	4,563	235	4,483	245	4,686
Decatur	Tennessee Quality HH-South West	1,080	37,708	1,082	41,010	1,352	45,155	1,080	37,708
	Volunteer Home care	1,534	51,090	1,503	59,191	1,598	62,863	1,401	61,060
Dyer	Regional Homecare -Dyer	707	24,161	814	25,936	744	25,147	655	19,817
Fayette	NHC Homecare	226	8,535	217	9,043	254	10,899	254	12,060
	Where the heart IS	116	3,487	271	3,658	253	1,453	34	736
Gibson	NHC-Gibson	569	17,601	625	19,744	479	20,667	546	21,723
	Volunteer Homecare -Gibson	3,041	77,139	3,027	75,415	2,549	71,266	2,443	70,172
Hardin	Deaconess Homecare-Hardin	1,330	42,646	1,244	52,175	1,213	55,013	1,124	50,863
	HMC Home Health	341	10,437	274	10,151	252	10,550	308	12,379
Henderson	Regional Home Care-Lexington	569	21,853	616	25,069	578	23,948	683	26,690
Henry	Henry CountyMedical Center-HH	363	7,276	399	8,070	355	7,517	474	10,087
Madison	Amedisys HHC-Madison	2,741	93,572	2,586	85,497	2,489	87,882	2,407	87,880
	Extendicare HH of West Tenn	1,085	32,356	993	32,457	962	38,306	1,015	42,079
	Intrepid USA	422	17,257	86	2,763	294	8,013	210	7,381
	Medical Center Home health	1,706	36,648	1,617	42,307	1,403	44,333	1,329	39,860
	Regional Home care-Jackson	1,164	41,439	1,061	not recorded	1,206	44,628	969	32,423
Obion	Extendicare HH of WTN-Obion	302	8,245	347	10,600	398	16,888	499	20,902
Tipton	Baptist Memorial Hosp HH-Covington	353	5,281	361	5,959	326	4,491	330	4,601
Weakley	CareAll Home care -University HH	2,036	74,987	2,668	116,347	1,903	123,638	1,902	92,329

TN.gov JAR reports

Attachment Section C, Need, Item 6

County	Agency	current patient	current visits	2012 patients	2012 visits	2011 patients	2011 visits	2010 patients	2010 visits
Tipton	Professional Home Health D/B/A CareAll	1,556	52,400	1,103	63,633	1,491	81,120	1,424	85,421
		2015 patients	2015 visits	2016 Patients	2016 Visits				
		1,123	41,398	1,183	42,226				

Tennessee Department of Health JAR Reports

(47)

Attachment Section C, Economic Feasibility

Item 2

CareAll
Home Care Services

December 11, 2013

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building
500 Deaderick Street, 9th Floor
Nashville, TN 37243

Dear Director,

The funding source for the project proposed with the CON application to relocate the principle location of Professional Home Health Care, LLC D/B/A CareAll Homecare Services from Covington, TN to Brownsville, TN will be from cash reserves. I attest that Professional Home Health Care; LLC D/B/A CareAll Homecare Services have sufficient cash reserves to fund this project.

Sincerely,

Michael Carell, President
CareAll, LLC

Attachment Section C, Economic Feasibility

Item 4

Historical and Projected Data Charts

Attachment: Section C, Economic Feasibility, Item 4

PROFESSIONAL HOME HEALTH CARE
CON CHANGE APPLICATION
HISTORICAL DATA CHART

	YEAR 2010
UTILIZATION DATA (VISITS)	78,390
REVENUE FROM SERVICES TO PATIENTS	
OUTPATIENT SERVICES REVENUE	20,471,904
NET OPERATING REVENUE	20,471,904
OPERATING EXPENSES	
SALARIES & WAGES	7,674,036
SUPPLIES	145,821
TAXES	578,616
DEPRECIATION	9,624
RENT	136,434
INTEREST	
MANAGEMENT FEES	4,826,832
OTHER EXPENSES *	1,633,869
TOTAL OPERATING EXPENSES	15,005,232
OTHER REVENUE (EXPENSES) **	135,513
NET OPERATING INCOME (LOSS)	**5,602,185**

Auto & Mileage		315,190
Employee Benefits		299,534
Insurance		245,961
Contract Services		174,998
Phone/Utilities		99,181
Advertising		73,694
Other Administrative		425,311
OTHER EXPENSES	*	**1,633,869**
Miscellaneous Income		110,380
Interest Income		25,133
OTHER REV (EXP)	**	**135,513**

PROFESSIONAL HOME HEALTH CARE
CON CHANGE APPLICATION
HISTORICAL DATA CHART

	YEAR 2011
UTILIZATION DATA (VISITS)	70,478
REVENUE FROM SERVICES TO PATIENTS	
OUTPATIENT SERVICES REVENUE	18,600,263
NET OPERATING REVENUE	18,600,263
OPERATING EXPENSES	
SALARIES & WAGES	6,850,487
SUPPLIES	141,621
TAXES	619,183
DEPRECIATION	26,811
RENT	134,760
INTEREST	
MANAGEMENT FEES	4,572,713
OTHER EXPENSES *	1,364,467
TOTAL OPERATING EXPENSES	13,710,042
OTHER REVENUE (EXPENSES) **	(1,009,394)
NET OPERATING INCOME (LOSS)	**3,880,827**

Auto & Mileage		289,899
Employee Benefits		271,970
Insurance		232,516
Contract Services		180,659
Advertising		104,401
Phone/Utilities		90,713
Other Administrative		194,309
OTHER EXPENSES	*	**1,364,467**
Miscellaneous Income		171,795
Interest Income		15,373
Bad Debts		(1,196,562)
OTHER REV (EXP)	**	**(1,009,394)**

PROFESSIONAL HOME HEALTH CARE
CON CHANGE APPLICATION
HISTORICAL DATA CHART

	YEAR 2012
UTILIZATION DATA (VISITS)	47,769
REVENUE FROM SERVICES TO PATIENTS	
OUTPATIENT SERVICES REVENUE	16,198,731
NET OPERATING REVENUE	16,198,731
OPERATING EXPENSES	
SALARIES & WAGES	6,482,351
SUPPLIES	137,953
TAXES	1,298,265
DEPRECIATION	30,069
RENT	131,880
INTEREST	3,056
MANAGEMENT FEES	3,834,542
OTHER EXPENSES *	1,040,870
TOTAL OPERATING EXPENSES	12,958,986
OTHER REVENUE (EXPENSES) **	(3,113,386)
NET OPERATING INCOME (LOSS)	**126,359**

Insurance		251,291
Auto & Mileage		214,542
Employee Benefits		185,038
Advertising		113,938
Phone/Utilities		72,328
Contract Services		14,905
Other Administrative		188,828
OTHER EXPENSES	*	**1,040,870**

Interest Income		19,947
Legal Settlement		(3,133,333)
OTHER REV (EXP)	**	**(3,113,386)**

PROFESSIONAL HOME HEALTH CARE
CON CHANGE APPLICATION
PROJECTED DATA CHART

	YEAR 2015
UTILIZATION DATA (VISITS)	41,398
REVENUE FROM SERVICES TO PATIENTS	
OUTPATIENT SERVICES REVENUE	11,188,573
NET OPERATING REVENUE	11,188,573
OPERATING EXPENSES	
SALARIES & WAGES	5,716,390
SUPPLIES	86,196
TAXES	563,394
DEPRECIATION	25,623
RENT	94,460
INTEREST	
MANAGEMENT FEES	2,144,284
OTHER EXPENSES *	1,220,318
TOTAL OPERATING EXPENSES	9,850,665
OTHER REVENUE (EXPENSES) **	(206,990)
NET OPERATING INCOME (LOSS)	**1,130,918**

Auto & Mileage		148,725
Employee Benefits		222,839
Insurance		268,004
Contract Services		103,495
Phone/Utilities		74,606
Advertising		97,707
Other Administrative		304,942
OTHER EXPENSES	*	**1,220,318**

Bad Debts		(206,990)
OTHER REV (EXP)	**	**(206,990)**

PROFESSIONAL HOME HEALTH CARE
CON CHANGE APPLICATION
PROJECTED DATA CHART

		YEAR 2016
UTILIZATION DATA (VISITS)		42,226
REVENUE FROM SERVICES TO PATIENTS		
OUTPATIENT SERVICES REVENUE		11,412,345
NET OPERATING REVENUE		11,412,345
OPERATING EXPENSES		
SALARIES & WAGES		5,773,554
SUPPLIES		87,058
TAXES		569,028
DEPRECIATION		25,879
RENT		94,460
INTEREST		
MANAGEMENT FEES		2,187,169
OTHER EXPENSES *		1,233,222
TOTAL OPERATING EXPENSES		9,970,370
OTHER REVENUE (EXPENSES) **		(211,130)
NET OPERATING INCOME (LOSS)		**1,230,845**

Auto & Mileage		150,212
Employee Benefits		225,067
Insurance		270,684
Contract Services		105,565
Phone/Utilities		75,017
Advertising		98,684
Other Administrative		307,993
OTHER EXPENSES	*	**1,233,222**

Bad Debts		(211,130)
OTHER REV (EXP)	**	**(211,130)**

Attachment Section C, Economic Feasibility

Item 6, b.

Attachment Section C, Item 6 B

County	Agency	Charges HH aide	charges MSS	Charges OT	Charges PT	Charges SN	Charges ST
Benton	Tennessee Quality HH-North West	43	153	105	104	95	113
Decatur	Tennessee Quality HH-South West	43	153	105	104	95	113
Dyer	Regional HH-Dyer	129	129	0	129	129	0
Gibson	Volunteer HH	44	155	0	106	96	0
Henderson	Regional HH-Lexington	90	200	175	175	160	165
Henry	Henry Co Medical Center	43	153	0	104	95	113
Madison	Extendicare of WT	50	252	186	221	105	180
	Intrepid	75	154	0	153	136	154
	Regional Home care	44	155	107	106	97	115

Tn.gov JAR reports

Attachment Section C, Economic Feasibility

Item 8

CareAll
Home Care Services

December 11, 2013

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building
500 Deaderick Street, 9th Floor
Nashville, TN 37243

Dear Director,

The funding source for the project proposed with the CON application to relocate the principle location of Professional Home Health Care, LLC D/B/A CareAll Homecare Services from Covington, TN to Brownsville, TN will be from cash reserves. I attest that Professional Home Health Care; LLC D/B/A CareAll Homecare Services have sufficient cash reserves to fund this project.

Sincerely,

Michael Carell, President
CareAll, LLC

Attachment Section C, Economic Feasibility

Item 10

Professional Health Care
Balance Sheet
October 31, 2013

ASSETS

Current Assets	
Cash	1,566,389
Accounts Receivable	2,258,902
Prepaid Insurance	31,033
Intercompany Due (To) From Careall, LLC and MGMT	(101,022)
Intercompany Due (To) From Agencies	826
Total Current Assets	3,756,127
Fixed Assets	
Vehicles, Equipment, Computer Hardware	131,118
Less: Accum Depreciation	(114,772)
Total Fixed Assets	16,346
Other Assets	4,098
Total Assets	3,776,571

LIABILITIES

Current Liabilities	
Accounts Payable	22,771
Other Current Liabilities	30,263
Accrued Worker's Comp Insurance	186,721
Accrued PTO	46,958
Deferred Revenue	42,162
Management Fees Payable	7,004,836
Total Current Liabilities	7,333,710

EQUITY

Retained Earnings - Current Year	1,758,329
Retained Earnings - Prior	(5,331,619)
Paid-in-Capital	646,650
Common Stock	1,000
Distribution	(631,500)
Total Equity	(3,557,140)
Total Liabilities and Equity	3,776,571

PROFESSIONAL HEALTHCARE
COMBINED INCOME STATEMENT
JANUARY 1 - OCTOBER 31, 2013

	OCTOBER 31, 2013 YTD
REVENUE:	
COMMERCIAL INSURANCE	$205,622
MEDICARE A	$4,564,308
MEDICARE B	$30,259
HOME HEALTH TENNCARE	$4,426
PRIVATE DUTY (TENNCARE)	$4,274,251
PRIVATE DUTY (COMM INS)	$1,051,245
PRIVATE DUTY (PRIVATE PAY)	$57,391
SITTER REVENUE	$479,028
MEDICARE/TENNCARE REV ADJ.	($47,736)
INTEREST/SUPPLIES/MISC INCOME	$19,012
TOTAL REVENUE	**10,637,806**
DIRECT LABOR COST:	
HOME HEALTH AGENCIES:	
SALARIES	1,156,764
FICA	85,978
MILEAGE	98,442
TOTAL HOME HEALTH AGENCIES	**1,341,185**
PRIVATE DUTY:	
SALARIES	3,144,314
FICA	236,697
MILEAGE	13,897
TOTAL PRIVATE DUTY	**3,394,907**
TOTAL DIRECT LABOR COST	**4,736,092**
CMS SUPPLY PURCHASES	**74,268**
PLANT OPERATIONS:	
PLANT OPERATIONS - RENT	88,830
PLANT OPERATIONS - UTILITIES	29,540
TOTAL PLANT OPERATIONS	**118,370**
ADMINISTRATIVE PAYROLL:	
SALARIES - ADMINISTRATOR	56,462
SALARIES - DIRECTOR	242,348
SALARIES - PCC	121,352
SALARIES - PI COORDINATOR	17,856
SALARIES - OFFICE	374,140
QUARTERLY DIRECTOR/ADM. BONUS	45,773
BONUS - REFERRAL/NON-MGT	1,191
FICA - G&A	128,252
TOTAL ADMINISTRATIVE PAYROLL	**987,375**

PROFESSIONAL HEALTHCARE
COMBINED INCOME STATEMENT
JANUARY 1 - OCTOBER 31, 2013

	OCTOBER 31, 2013 YTD
ADMINISTRATIVE - OTHER:	
MANAGEMENT FEES	1,968,236
PRE-CERT FEES	139,300
OASIS FEES	95,920
NURSE CONSULTING	13,104
PENSION	3,816
WORKERS COMPENSATION	186,721
VESTED PTO	104,651
GROUP INSURANCE	130,245
OTHER BENEFITS (STD, LIFE)	13,331
STORAGE/MOVING FEES	4,227
SEMINAR/BOOK EXPENSE	2,729
UNIFORMS	1,363
ADVERTISING/MARKETING	111,785
EMPLOYEE ADS	222
TEMPORARY HELP	1,657
BACKGROUND INVESTIGATIONS	5,608
MEDICAL ALARM MONITORING	11,973
COMPLIANCE/'TRAINING	107,871
EXPENDABLE EQUIPMENT	2,359
TELEPHONE	31,485
TELEPHONE ANSWERING SERVICE	1,650
DIRECTORY LISTING	1,525
POSTAGE	9,537
PRINTING & DUPLICATION	13,120
OFFICE SUPPLIES	45,301
MEDICAL CONSULTING FEES	18,475
LEGAL/ACCOUNTING FEES	28,549
INTEREST EXPENSE	7,639
SOFTWARE SUPPORT	14,120
DUES & SUBSCRIPTIONS	2,921
MEALS/LODGING/ENTERTAINMENT	6,146
MAINT/REPAIR/SERV. AGREEMENTS	14,612
BAD DEBTS	17,536
TAXES & LICENSES	75,326
FUEL EXPENSE	17,163
TOTAL OTHER ADMINISTRATIVE	**3,210,223**
AUTO & MILEAGE	**24,132**
DEPRECIATION	**22,964**
INSURANCE:	
PROF/LIABILITY INSURANCE	36,326
VEHICLE INSURANCE	3,061
TOTAL INSURANCE	**39,387**
TOTAL EXPENSES	**9,212,810**
NET INCOME FROM OPERATIONS	**1,424,996**
LEGAL SETTLEMENT REVERSAL	**333,333**
NET INCOME	**1,758,329**

PROFESSIONAL HEALTHCARE
COMBINED INCOME STATEMENT
January 1 - October 31, 2013

	2013 YTD SUBTOTAL	%
REVENUE:		
COMMERCIAL INSURANCE	205,622	1.93%
UNIVITA	-	0.00%
MEDICARE A	4,564,308	42.91%
MEDICARE B	30,259	0.28%
HOME HEALTH TENNCARE	4,426	0.04%
PRIVATE DUTY (TENNCARE)	4,274,251	40.18%
PRIVATE DUTY (COMM INS)	1,051,245	9.88%
PRIVATE DUTY (PRIVATE PAY)	57,391	0.54%
SITTER REVENUE	479,028	4.50%
MEDICARE/TENNCARE REV ADJ.	(47,736)	-0.45%
INTEREST/SUPPLIES/MISC INCOME	19,012	0.18%
TOTAL REVENUE	10,637,806	100.00%

MEDICARE ADJ	(50,439)
TENNCARE ADJ	2,703
TOTAL ADJ	(47,736)

OCT YTD 2013 SUMMARY:			% APPLIED TO 2015 PROJECTION	
COMMERCIAL INSURANCE	1,256,867	11.84%	1,324,307	COMMERCIAL INSURANCE
MEDICARE	4,544,128	42.79%	4,787,955	MEDICARE
TENNCARE	4,760,408	44.83%	5,015,840	TENNCARE
SELF PAY	57,391	0.54%	60,470	SELF PAY
TOTAL	10,618,794	100.00%	11,188,573	
INTEREST	19,012			
	10,637,806		11,188,573	

Attachment Section C, Contribution to the Orderly Development of Health Care

Item 3

Section C: Contribution to Orderly Development of Health Care, Item 3

Position Title	Current FTE	Proposed FTE	Net Change	Agency average annual wage	Average annual wage for the service are of Tennessee
Administrator	1	1	0	$65,000	$83,160
Director of Patient Services	6	5	-1	$55,000	$77,190
Office Coordinators	11	10	-1	$22,800	$41,390
LPN Patient care Coordinators	6	6	0	$33,280	$31,300
Field RN	6	6	0	$49,287	$52, 220
Field LPN	4	4	0	$37,349.00	$34,610
LPTA	6	6	0	$66,915	$58,440
Field PT	2	2	0	$166,675	$92,570
Field Home Health Aide	3	3	0	$22,880	$20,460
Field Speech Therapy	0.5	0.5	0	$70,000	$71,900
Field Medical Social Services	1	1	0	$31,200	$43,470
Field Ocupational Therapy	0.5	0.5	0	$85,000	$86,200
Total	47	45	-2	$43,940	$61,935

The 2013 Tennessee Occupational wages, BOS area 470001 West Tennessee, Health Practitioners and Technical Occupations, Management Occupations, Health Care and Support Occupations, Office and Administrative Occupations, Community and Social Service Occupations.

Attachment Section C, Contribution to the Orderly Development of Health Care

Item 5

Policy Description:	Number:
PHYSICIAN MANAGEMENT	**02.011**

PURPOSE:

The purpose of this policy is to provide Agency guidelines on physician management.

PHYSICIAN MANAGEMENT:

The following policies/procedures describe the responsibilities of physicians managing the medical care of the Agency's patients and the responsibilities of the Agency to assist in the provision of medical care.

Frequency of Physician/Patient Contact:

The physician shall see the patient for office visits as the patient's condition warrants or as the physician deems necessary, according to the patient's condition. Physician/patient contact will also occur in the event of an emergency that necessitates the patient being taken to the emergency room or physician's office. The Agency staff will notify the patient's physician for any changes in the patient's condition that might warrant changes in the patient's plan of care. Admitting professionals will inform patients at time of admission and on-going of their responsibility to notify Agency staff and/or physician of any changes in conditions that might warrant patient/physician contact.

Physician Provision of Patient Information to Staff:

The patient's physician will provide complete and accurate information about the patient to Agency staff by providing accurate referral information by telephone or in writing; submission of plan of care orders and recertification orders, if appropriate; supplemental orders; telephone care conferences; lab results, if performed by physician; and any other information relevant to the patient's care (i.e., unusual home environment, changes in condition, history, physical, etc.). The physician will communicate such information to Agency staff by telephone, fax machine, in writing, in person, etc. in a clinical language that is understandable to the staff, with further clarification upon request.

Agency Provision of Patient Information to Physician:

The Agency staff will provide complete and accurate information about the patient to the physician by providing information about changes in patient's condition, psychosocial status, mental status, environmental status, physical status, etc. that may impact care delivery in the home setting and/or inability to achieve established plan of care goals. The Agency staff will communicate with the physician by telephone and/or in person and will submit plans of care and supplemental orders in writing for verification and signature. The physician will receive appropriate summary progress report(s) from the Agency about his/her patient. The physician will receive results of lab tests, etc. that are performed on behalf of the Agency, under the physician's order. The staff will communicate such information to the physician by telephone, fax machine, in writing, in person, etc. in a clinical language that is understandable by the physician, with further clarification upon request.

Physician and Staff Availability:

The patient's physician and/or the physician's designated on-call coverage physician(s) will be available to staff 24 hours/day, seven days/week. The physician will respond to Agency staff calls as soon as possible/feasible.

The Agency will have an LPN and/or RN available to the physician 24 hours/day, seven days/week. The LPN and/or RN will respond to the physician calls as soon as possible/feasible. There will always be an RN available when the LPN is the primary on-call nurse.

Policy Description:	*Number:*
PHYSICIAN MANAGEMENT	**02.011**

Orders:

The physician will provide signed plan of care orders and supplemental orders according to Agency policy.

Continuity of Care:

The physician will designate the hospital to be used in the event of an emergency. (Note: The hospital to be used is typically the hospital at which the physician has admitting privileges and/or is agreeable with the patient.)

In the event that the physician is not available to staff, the physician will have another physician designated in his office and/or through his answering service that is available to staff. Physician's office and/or answering service should always know and convey to staff who the alternate physician is.

Any physician referral to other organizations or specialty physician that affects the care provided by the Agency will be communicated to the staff by the physician.

Clinical Updates:

Agency staff will provide written clinical updates to the patient's physician at least every 60 days by means of a summary written progress report. Verbal and/or other written reports will be provided to the physician as the patient's condition warrants.

Confidentiality of Communication:

All communication between the patient's physician and Agency staff will be kept confidential per Agency policy.

Policy Description:	Number:
STAFF QUALIFICATIONS	**02.006**

PURPOSE:

The purpose of this policy is to establish the minimum acceptable staff qualifications for Agency positions.

STAFF QUALIFICATIONS:

Registered Nurse:

The Agency shall employ registered professional nurses who:

- Hold a CURRENT license to practice professional nursing in the state where services are provided.
- Prefer a minimum of one (1) year of work experience as a professional nurse

Licensed Practical Nurse:

The Agency shall employ licensed practical nurses who:

- Hold a CURRENT license to practice practical nursing in the state where services are provided.
- Prefer a minimum of one (1) year of work experience as a practical nurse

Physical Therapist:

The Agency shall employ physical therapists who:

- Hold a CURRENT license to practice physical therapy in the state where services are provided.
- Prefer a minimum of one (1) year work experience as a physical therapist

Physical Therapist Assistant:

The Agency shall employ physical therapy assistants who:

- Hold a CURRENT license and/or certification as a physical therapy assistant in the state where services are provided.
- Prefer a minimum of one (1) year of work experience as a physical therapy assistant

Social Worker:

The Agency shall employ social workers who:

- Have a Masters degree from a school accredited by the Council on Social Work Education.
- Hold a CURRENT license and/or certificate as a medical social worker in the state where services are provided.
- Have one (1) year of social work experience in a health care setting.

Social Work Assistant:

The Agency shall employ social work assistants who:

- Have a Baccalaureate degree in social work, psychology, sociology, or other field related to social work.

- Have one (1) year social work experience in a health care setting or has two (2) years of appropriate experience as a social work assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Services, except that these determinations of proficiency do not apply with respect to persons initially licensed by a state or seeking initial qualifications as a social work assistant after December 31, 1997.

Speech Pathologist/Audiologist:

The Agency shall employ Speech Pathologists/Audiologists who:

- Hold a CURRENT license and/or certification to practice Speech Pathology/Audiology in the state where services are provided.
- Prefer a minimum of one (1) year work experience as a Speech Pathologist/Audiologist.

Occupational Therapist:

The Agency shall employ occupational therapists who:

- Hold a CURRENT license and/or certification as an occupational therapist in the state where services are provided.
- Prefer a minimum of one (1) year of work experience as an occupational therapist.

Occupational Therapy Assistant:

- Hold a CURRENT license and/or certification as an occupational therapy assistant in the state where services are provided.
- Prefer a minimum of one (1) year of work experience as an occupational therapy assistant.

Home Health Aide:

The Agency shall employ only home health aides who:

- Have reading and writing skills necessary to the performance of their job.
- Have the ability to carry out directions.
- Have the maturity and ability to deal effectively with the demands of the job.
- Have completed a basic aide training program and possess a certificate of course completion -- the number of required hours of training shall be in accordance with Medicare conditions of participation and/or the State Licensure Laws, whichever is more stringent.

Requirements for Medicare Home Health:

Have documented evidence of a total of 75 hours of training; at least 16 hours of classroom training must be completed prior to 16 hours of supervised practical training. The training content must be in accordance with the Conditions of Participation. Successfully complete a competency evaluation.

Requirements for the State of Tennessee:

Complete a minimum of 60 hours of instruction, including 16 hours of classroom instruction, prior to or during the first three months of employment.

Policy Description:	*Number:*
STAFF QUALIFICATIONS	**02.006**

CNT/CNA:

The Agency shall employ companions and/or sitters who:

- Have reading and writing skills necessary to the performance of their job.
- Have the ability to carry out directions.
- Have the maturity and ability to deal effectively with the demands of the job.
- Have completed a basic aide training program and who have been found competent by the State to furnish those services by means of certification.

Policy Description:	*Number:*
PERSONNEL RECORDS	**02.007**

PURPOSE:

The purpose of this policy is to establish guidance in regards to Agency's personnel records.

PERSONNEL RECORDS:

Personnel records shall be maintained on all employees. These records will be kept in a locked file and safeguarded from unauthorized use. Personnel records should contain the following as applicable:

Employee File:

- Application and/or Resume
- Personal/Employment References (2)
- Copy of W-4 and I-9 Forms (VA-4 form as applicable)
- Copy of Social Security Card
- Copy of Driver's License
- Licensure/Certification/Competency (as applicable)
- Verification of Professional Licensure/Certifications (as applicable)
- Statement of Criminal History/Abuse Registry
- CPR Certification (as applicable)
- Auto Insurance Verification
- Agency Insurance Enrollment/Waiver Form
- Signed Job Description
- Signed Orientation Checklist (as applicable)
- Safety Rules Form
- Statement of Confidentiality/HIPPA
- Corporate Compliance Form
- Verification for Review of Agency Policies
- Uniform and CareAll Bag Agreement
- Bag/Equipment Loan Agreement
- Supply Policy Form
- Contract (as applicable)
- Pre-Employment Exams/Competency Evaluations/Proficiency and Skills Assessments (as applicable)
- Performance Evaluations/Commendations/Disciplinary Actions
- In-Service Records and Continuing Education (as applicable)
- Acknowledgement of Per Visit Compensation (as applicable)

- Payroll Agreement

Health File:

- Completed Medical/Physical Questionnaire or Exam
- TB Skin Test or Chest X-Ray Result (as applicable)
- Hepatitis B Vaccination/Declination Form
- Consent for Drug Test
- Lab Test Results

Personnel records shall be maintained for five years after termination of employment. Medical records of employees with occupational exposure shall be retained for the duration of employment plus thirty (30) years. Records are protected from damage and unauthorized use. Applications for employment of persons not employed by the Agency will be maintained on file for three (3) months. These applications will be kept in the Agency's individual office where the application was made. It shall be the Agency's policy to reply to written requests for information on former employees, providing the Agency has written authorization from the employee to do so. Dates of employment will be the only information verified by the office where the employee worked. All requests for references or any other information on employees may be obtained only through requests to the Corporate Office.

Policy Description:	Number:
STAFF SUPERVISION	**02.012**

PURPOSE:

The purpose of this policy is to establish the Agency's guidelines on supervision of staff, supplemental employees and/or contractor(s).

STAFF SUPERVISION:

The Agency shall retain all rights and responsibilities for the administration and control of services provided to all patients by its staff, supplemental employees and/or contractor(s). In no instances shall the administrative or supervisory responsibilities be delegated to another Agency. The supervision of services provided by contracts shall be in accordance with the provisions specified in the signed agreements. All services provided through contract shall be monitored and controlled by the Agency.

The Agency shall provide access to qualified consultation in the event the professional and/or supervisor do not have appropriate clinical training and experience for a clinical specialty area. The supervisor shall be responsible for coordinating appropriate training. This training shall be provided by a qualified individual with education and experience in the clinical specialty area.

All services provided by the Agency are appropriately supervised and evaluated. The supervisor or a designated qualified alternate is available on the premises or by telecommunications at all times to provide on-going supervision.

Skilled Nursing Services:

All skilled nursing services offered by the Agency shall be provided by a qualified registered and/or licensed practical nurse.

The supervisor shall make an on-site supervisory visit on a random basis and/or as deemed necessary to observe and evaluate the nurses performance, patient care, coordination of services, organization and time management, documentation and other aspects of their performance as indicated. In addition, the Agency shall verify the competency level of professional nurses prior to providing high-tech procedures requiring specialized training. When indicated, the professional nurse shall attend specific high-tech procedural in-services.

All patients receiving services provided primarily by the licensed practical nurse shall be supervised by a registered nurse at least every 60 days by a visit to the patient's home. The registered nurse shall be responsible for the overall coordination of the plan of care.

Therapy Services (Physical and Occupational Therapy):

All therapy services offered by the Agency shall be provided by a qualified therapist or by a qualified therapy assistant.

The supervisor shall make an on-site visit on a random basis and/or as deemed necessary. Patients receiving services provided by the therapy assistant shall be supervised by a registered therapist at least every month by a visit to the patient's home.

For patients receiving physical therapy services longer than 60 days, the licensed physical therapist shall inspect the actual act of therapy services rendered at least every 60 days.

Speech Therapy Services:

All speech therapy services offered by the Agency shall be provided by a qualified speech therapist.

The supervisor shall make an on-site supervisory visit on a random basis and/or as deemed necessary to observe and evaluate the individual's performance.

Social Services:

All social services offered by the Agency shall be provided by a qualified social worker or by a qualified social work assistant, per applicable state regulations.

The supervisor shall make an on-site visit with each social worker and/or social work assistant to observe and evaluate the social worker's performance on a random basis and/or as deemed necessary.

All social work assistant services will be under the general supervision of a Masters level social worker. The social worker shall do a case review, on a monthly basis, of all patients seen by the social work assistant.

Personal Care Services:

All personal care services offered by the Agency shall be provided by an appropriately trained, certified, and/or competent home health aide under the direction of the registered nurse. The registered nurse shall make a random on-site visit with each home health aide to observe and evaluate the individual's performance annually and/or as deemed necessary.

When the patient is receiving Medicare skilled nursing, physical, speech or occupational therapy, a registered nurse must make a supervisory visit to the patient's residence at least once every 14 days, either when the aide is present to observe and assist, or when the aide is absent, to assess relationships and determine whether goals are being met. When only physical, speech, or occupational therapy is furnished in addition to the aide services, a skilled therapist may make the supervisory visits in place of a registered nurse.

A registered nurse will make a supervisory visit to all other clients receiving skilled nursing and/or special discipline(s) care in conjunction with aide services at least monthly. For patients requiring aide services only, a registered nurse will make an on-site supervisory visit at least once every 60 days.

The supervisory visit may be made either when the aide is present to observe the aide in the performance of their duties or when the aide is absent to determine the relationship with the client, whether care is being given according to the schedule and whether the goals are being met. In addition to visits by the registered nurse, visits by the therapist may be made to supervise the aide in their performance of therapy related duties.

In regard to aide supervisory visits, the supervising nurse or therapist shall complete an aide supervisory note for each supervisory visit made indicating whether the aide was present or absent. If skilled care was provided during the visit the professional will complete a progress note and document the supervisory evaluation of the aide.

Performance Evaluations:

Staff appraisal is provided on a daily basis through record reviews, individual or group discussions with staff and in-home observations. In addition, a formal performance evaluation shall be completed at the end of the introductory period and annually thereafter.

Policy Description:	*Number:*
ASSIGNMENTS AND STAFFING	**02.013**

PURPOSE:

The purpose of this policy is to establish the Agency's guidelines on assignments and staffing.

ASSIGNMENTS AND STAFFING:

Assignments:

The Administrator's assignments are decided upon by the Board of Directors. The management staff receives assignments from the Administrator (or appointed delegate). The administrative-clerical personnel receive assignments from management. Professional staff, contracted staff and home health aide staff assignments are reviewed and approved by the director/manager.

Patient care assignments are made with consideration of the patient population served and patient care needs and in accordance with staff's skill level. Race, creed, color, ancestry, national origin, sex, sexual preference, age, handicap or veteran status of staff or patients will not be considered when making staff assignments. Whenever possible, an attempt will be made to maintain consistency of personnel assigned to patients.

Staffing:

The Agency ensures the availability of sufficient staff by routinely reviewing the staff to patient ratios. Full-time staff is assisted by supplemental personnel to accommodate fluctuating caseloads.

A current list of active personnel shall be maintained by the Agency which contains the name and position of all persons employed by the Agency.

A current list of active patients shall be maintained by the Agency which contains the patient's name and other pertinent information.

In the case of visiting staff, scheduling of visits will be the responsibility of the director/manager or designated staff.

Professional Services:

Upon receipt of a referral, the director/manager, or designated staff, will assign the patient to the admitting professional based on the knowledge, training and expertise of the staff and the needs of the patient.

Upon completion of the initial assessment the case shall be assigned to the visiting professional(s) assigned to the geographic area.

It will be the responsibility of the director/manager, or designated staff, to determine whether the case load requirements of each employee require adjustment or reassignment of cases.

The director/manager, or designated staff, will make the appropriate staff assignment(s).

Schedules shall be maintained for all visiting staff for one (1) calendar year.

Personal Care Services:

Upon receipt of an aide assignment the director/manager, or designated staff, shall review the care requirements of the patient.

The person responsible for scheduling shall complete the appropriate schedule weekly.

Policy Description:	*Number:*
ASSIGNMENTS AND STAFFING	**02.013**

The aide receives his/her schedule on at least a weekly basis. Each staff member should maintain regular contact with the office.

The director/manager, or designated staff, shall be responsible for arranging for the services according to the appropriate plan of care.

If an individual encounters difficulties in providing care/services or the patient/caregiver is unhappy about the time of the service, the individual is to contact the director/manager, or designated staff.

The director/manager, or designated staff, shall review and approve changes to the schedule.

Policy Description:	Number:
REFERRAL AND PRE-CERTIFICATION	**03.001**

PURPOSE:

The purpose of this policy is to outline the Agency's referral and pre-certification process.

REFERRAL AND PRE-CERTIFICATION:

New patient referrals may be accepted by a licensed nurse or therapist. If a licensed nurse or therapist is not immediately available a clerical staff member may obtain pertinent information and arrange for the licensed nurse or therapist to verify referral information with the referral source. Referrals may be accepted from physicians, physician's offices, patients, patient's caregivers, or other allied health personnel. Referrals may be accepted by telephone, in person, by mail or by facsimile machine. The director/manager and/or Administrator shall oversee appropriate admission staff assignments based on the population and needs of patients served and the knowledge, training, and experience of staff members.

The Agency will have procedures for the receipt, processing, and evaluation of persons referred for service. A log of all persons referred for service will be maintained. Persons rejected will be noted along with the reason for rejection. Persons residing outside of the service area or in need of services not provided by the Agency will be assisted in contacting the appropriate resources.

Upon acceptance of a referral, pre-certification and/or verification of eligibility will be performed by the management company and an assessment evaluation by a registered nurse or appropriate therapist will be made to determine that the care can be adequately and safely performed at home, to assess the patient care needs, and to ensure that the patient meets the admission criteria. The pre-certification and/or verification of eligibility shall be completed by the management company within 24 hours of the receipt of the referral. The assessment evaluation shall occur within 48 hours of receipt of the referral or within 48 hours of the patient's return home unless otherwise ordered by the physician. Should a referral be made for services such as physical, occupational and/or speech therapy and/or social services) then their initial evaluation shall occur within five to seven business days. When rehabilitation therapy service (physical therapy or speech therapy) is the only service ordered by the physician, the initial assessment evaluation visit may be made by the appropriate rehabilitation skilled professional within 48 hours as defined above.

PROCEDURE:

1. Upon receipt of a referral the following will occur:
   - Complete a Referral form.
   - Contact the physician to obtain approval to visit, verify information, medical orders, etc., for referrals not received directly from the physician.
   - Verify that the physician is licensed according to state/federal regulations.
   - Determine if the patient has been a previous patient of the Agency.
   - Complete a pre-certification form and submit to the management company.
   - Verify that admission criteria are met.
   - Verify insurance information on the referral form with findings on the pre-certification form and obtain approval for visits if required.

- Obtain assignment of a medical record number.

2. If unable to accept referral, enter referral on non-admit log along with reason for non-admission.
3. The clerical staff will complete a non-admit report and forward copies to the Administrator.

Policy Description:	*Number:*
INTRODUCTION	**04.001**

INTRODUCTION:

The Agency is a multi-disciplined home health service. To fulfill the home health's stated mission of providing quality care to all our patients/clients in the most cost effective manner, the Board of Directors have put into action a comprehensive integrated and Performance Improvement Plan for the home care providers.

The agency's Board of Directors and other Administrative leaders shall set expectations, develop plans and implement on-going systematic and objective procedures to evaluate, measure, assess and improve the performance of the organization's governance, management, clinical and support processes.

The agency's leaders shall set priorities to guide the agency in its performance improvement activities that are designed to improve the quality of patient care, resolve identified problems, assess and improve new or existing processes. A necessary precursor to the agency's Board of Directors and leaders shall individually and jointly develop and participate in mechanisms to foster communications among individuals and among components of the organization, and too coordinate all internal activities. The leaders shall also assure that staff are trained in assessing and improving the process that contribute to improved patient/client outcomes.

In efforts to meet the expectations of Performance Improvement the agency's leaders shall:

- Allocate resources for monitoring, assessment and improvement of the agency's governance, managerial, clinical and support processes.
- Encourage personnel to participate in performance improvement activities.
- Provide adequate time for personnel to participate in performance improvement activities.

Policy Description:	*Number:*
PERFORMANCE IMPROVEMENT PLAN	**04.002**

PURPOSE:

1. To describe the Agency's performance improvement program.
2. To ensure a planned, systematic approach for performance improvement activities.
3. To define expectations for performance improvement activities.
4. To coordinate performance improvement activities

PERFORMANCE IMPROVEMENT PLAN:

The agency maintains an established Performance Improvement program through a written plan. The program is continuously being created, reviewed, evaluated and reported to meet agency goals.

PROCEDURE:

The Agency's performance improvement program is implemented and evaluated on an on-going basis according to a written performance improvement plan which includes a description of it's:

1. Mission Statement
2. Philosophy
3. Definition
4. Purpose and Scope
5. Goals
6. Objective
7. Monitoring and Evaluation
8. Communication Activities reported by:
    a. Administrator to Board of Directors
    b. Performance Improvement personnel to Administrator
    c. Performance Improvement Committee Members to personnel and/or Administrator.
    d. Executive Director/Performance Improvement personnel and/or Administrator to all Agency Staff.
9. Statement of Confidentiality
10. Annual Performance Improvement Program Evaluation
11. Continuous Performance Improvement Activities using the PDCA Model:
    a. Problem Assessment
    b. Problem Identification
    c. Problem Selection
    d. Problem Study
    e. Corrective Action

f. Monitoring

g. Evaluation

h. Reassessment

12. Special Performance Improvement Studies may include, but are not limited to:

a. Satisfaction Surveys/Questionnaires

b. Operational Surveys such as:

- Departmental/Service Studies
- Clinical Record Review
- Program Indicators
- Annual Agency Evaluation
- Adverse Event Outcomes
- OASIS Data Control Audits
- Infection Control Surveys
- Safety/Risk Management Surveys
- Occurrence Report Studies
- On-call Logs
- Evaluation of Hiring Process
- Evaluation of Training/Education Process

c. Utilization Review Surveys such as:

- Utilization of Services by Discipline
- Services not Provided
- Patients not Accepted for Admission
- Reasons for Discharge
- Patients Readmitted to Hospital within 30 days of Hospital Discharge
- Patients Discharged from Home Care to Nursing Home
- Committee/Team Reports and Follow-up Studies
- Performance Improvement Studies

13. Documentation Methods for Performance Improvement activities may include, but are not limited to:
    a. Performance Improvement Annual Plan Calendar
    b. Performance Improvement Committee/Team Meeting Minutes
    c. Monitoring/Evaluation/Plan of Correction
    d. Evaluation of Performance Improvement Program
14. Internal Data Sources may include, but not limited to:
    a. Compliance Audit
    b. Utilization Review
    c. OASIS Data Control Audit
    d. Patient Complaint Form
    e. Staff Educational Program
    f. In-Home Observation/Supervision of Home Health Aides
15. External Data Sources may include, but not limited to:
    a. State/Federal Inspection Reports
    b. Adverse Events Outcome Reports
    c. ADR's

Policy Description:	*Number:*
PERFORMANCE IMPROVEMENT MISSION STATEMENT	**04.003**

PURPOSE:

The Performance Improvement program of the Agency carefully follows the Federal, State and Board of Directors guidelines for the provision of quality care to agency patients in the most cost-effective manner.

PERFORMANCE IMPROVEMENT MISSION STATEMENT:

The program is continuously being created, reviewed, evaluated and reported to meet our goals for providing an array of home health services at competitive prices to our patients in their place of residence, for the purpose of promoting, restoring and/or maintaining health and maximizing the chances of remaining at home. Additionally, every effort will be made to improve services, maintain a professional relationship with our customers, vendors and government agencies and provide technological advancement to improve our reputation in the home health care community.

Policy Description:	*Number:*
PERFORMANCE IMPROVEMENT PHILOSOPHY	**04.004**

PURPOSE:

1. To adopt the appropriate philosophical approach to providing top quality home health services.
2. To ensure every patient receives quality home health care.

PERFORMANCE IMPROVEMENT PHILOSOPHY:

Performance Improvement activities are guided by the overall philosophy and mission statement of the Agency.

PROCEDURE:

1. The adoption of the appropriate philosophical approach to providing top quality home health care services is based on the following basic assumptions:
    a. Each patient has the right to receive quality care.
    b. Each patient desires and has the right to the type and level of care that will promote the patient's maximum value of life by maximizing potential level of independence, minimizing potential negative illness and disability outcomes, and by promoting, restoring, and maintaining patient health
2. The recognition of our desire to provide high quality, appropriate, cost-effective care to all patients based on the following basic assumptions:
    a. The agency provides health care education for the patient, the patient's family and the community.
    b. The agency serves as a resource for the patient, the patient's family and the community.
    c. The agency advises the patient's family regarding community support services as needed.
    d. The agency involves the patient and/or their family in the patient's plan of care when at all possible.
    e. The agency is committed to the development and implementation, on an on-going basis, of a performance improvement program as we continue our efforts to promote the best service possible.
    f. On-going and comprehensive performance improvement activities are designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care.

Policy Description:	*Number:*
PERFORMANCE IMPROVEMENT DEFINITION	**04.005**

PURPOSE:

The purpose of this policy is to provide the agency's definition of the performance improvement program.

PERFORMANCE IMPROVEMENT DEFINITION:

The performance improvement program is an on-going, comprehensive program designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care as perceived by patients and their caregivers as meeting their needs. It is a means of identifying actual and potential problem areas and providing the means to resolve the problems and pursue opportunities to improve all aspects of patient care and services.

What is quality care?

Patients/clients view quality care as:

- Responsiveness to needs.
- Communication, concern and courtesy.
- Services provided as agreed upon.
- Functional improvement, system relief and remaining at home

Physicians view quality care as:

- Freedom to act in the full interest of the patient.
- Ability to practice profession according to professional standards.
- Feeling of helpfulness and usefulness.

Third party payers view quality care as:

- Effective use of available funds.
- Appropriate use of resources.

Policy Description:	*Number:*
PERFORMANCE IMPROVEMENT PURPOSE - SCOPE	**04.006**

PERFORMANCE IMPROVEMENT PURPOSE - SCOPE:

The role of the Governing Body is to issue the authority for the performance improvement programs.

Important functions include:

Organizational, which include:

- Rights, Responsibilities and Ethics
- Assessment
- Care, Treatment and Service
- Education
- Continuum of Care
- Leadership
- Management of Information
- Management of Human Resources
- Management of Environment
- Surveillance, Prevention and Control of Infection

Measurement and assessment of the important function may be assessed at some point in relation to dimension of performance that includes:

- Efficiency
- Appropriateness
- Availability
- Timeliness
- Effectiveness
- Continuity
- Safety
- Respect and Caring

Clients/customers include patients, referral source, physicians, discharge planners, agency leaders, agency staff and regulatory agencies.

Responsbility:

The Board of Directors of the agency is ultimately responsible for the quality of care delivered. The Administrator and the Performance Improvement personnel are responsible for the overall supervision of the performance improvement program. The Administrator delineates responsibility of the program activities to the Director of Patient Care Services.

Policy Description:	*Number:*
PERFORMANCE IMPROVEMENT GOALS	**04.007**

PURPOSE:

1. To ensure the focus on reducing patient related problems, complaints and occurrences.
2. To ensure the program is consistent with the agency's philosophy, mission statement and goals.

PERFORMANCE IMPROVEMENT GOALS:

The Agency is guided by the goals of the Performance Improvement program.

GOALS:

- Improved patient/client satisfaction.
- Improved patient/client care.
- Improved job satisfaction.
- Improved educational programs.
- Improved orientation programs.
- Improved clinical performance.
- Improved application of the nursing process.
- Improved infection control.
- Improved safety/risk management.
- Improved policies and procedures.
- Decreased occurrences and adverse events.
- Meet the conditions of participation for Medicare.

Policy Description:	*Number:*
PERFORMANCE IMPROVEMENT OBJECTIVES	**04.008**

PURPOSE:

To improve high quality home health care and to reduce or eliminate risk and hazards within the patient's environment.

PERFORMANCE IMPROVEMENT OBJECTIVES:

- Evaluating/or designing agency forms and policies which will meet patient/client and agency needs, through the establishment of committees/teams, specifically selected for their knowledge, experience and desire to promote quality products which will improve patient care.
- Administering and coordinating the agency's Performance Improvement program which is designed to ensure performance improvement and certain risk management's activities.
- Identifying opportunities to improve patient care using on-going collection and/or screening and evaluating information about important aspects of patient care.
- Tracking identified problems to ensure improvement or resolution.
- Developing and implementing effective Performance Improvement mechanisms such as monitoring and evaluation committees, occurrence reporting, trending and patient/physician questionnaires
- Documenting the findings, conclusions, recommendations, actions taken and results of actions taken.
- Overseeing the effectiveness of the program and detection of trends, patterns of performance or potential problems that may affect patient/client care.
- Improving communication among staff when problems or opportunities arise to improve patient/client care.
- Identifying at least annually the scope, organization and effectiveness of the Performance Improvement program.
- Identifying the need for revision in patient care services, policies and procedures.
- Achieve a high level of client/customer satisfaction.
- Design and assess new processes.
- Measure the level of performance and stability of important existing processes and identify areas for improvement.
- Determine whether changes improved the processes.
- Assess the dimension of performance relevant to functions, processes and outcomes.
- Meet regulatory standards.

Policy Description:	*Number:*
PERFORMANCE IMPROVEMENT ROLE	**04.009**

PURPOSE:

The Performance Improvement personnel has direct and unimpeded access to Senior Management and to the Board of Directors.

PERFORMANCE IMPROVEMENT ROLE:

A. Reviews the scope of care and percentages of compliance, interprets findings, evaluates and recommends corrective action and re-evaluates as necessary.

B. Plans and coordinates agency performance improvement activities.

C. May conduct performance improvement studies as indicated.

D. Establishes performance improvement priorities.

E. Assist agency committees in monitoring and evaluating activities.

F. May develop annual calendar for performance improvement activities.

G. Develops and/or provides workshops/inservices when indicated.

H. Advises and consults with the Administrator on performance improvement issues.

I. Assist in the annual evaluation of the effectiveness of the performance improvement program.

J. Will attend performance improvement activities and committee meetings.

Policy Description:	*Number:*
PERFORMANCE IMPROVEMENT COMMUNICATION	**04.010**

PURPOSE:

1. To ensure a planned, systematic approach for performance improvement activities.
2. To coordinate performance improvement activities.
3. To define expectations for performance improvement activities.

PERFORMANCE IMPROVEMENT COMMUNICATION:

The agency maintains an established communications plan for the performance improvement program.

PROCEDURE:

1. The performance improvement activities are reported directly to the Director, Administrator and Board of Directors.
2. The performance improvement findings of the program will be communicated through established channels in the organization, depending in the nature of the topic.
3. The Performance Improvement personnel will prepare reports which include the monitoring and evaluation activities, problem solving activities, recommendations, actions and follow-up.
4. The Administrator and/or the designee will disseminate information to the staff which includes conclusions, recommendations and activities in a timely, confidential manner.
5. Communication may be through, but not limited to:
    a. Committee meetings and/or minutes
    b. Annual evaluation of performance improvement activities
    c. Board of Directors minutes

Policy Description:	*Number:*
PERFORMANCE IMPROVEMENT CONFIDENTIALITY	**04.011**

PURPOSE:

1. To ensure adherence to confidentiality standards.
2. To ensure respect of patient rights.

PERFORMANCE IMPROVEMENT CONFIDENTIALITY:

The Performance Improvement program will maintain strict adherence to patient/staff confidentiality.

All data utilized or generated by performance improvement is protected from discovery as specified in the Tennessee code annotated sec. 63-623-1975, this means the reports, minutes and other data are designated as confidential by Tennessee state law; and all committee members, board members and executive management having access to the data are responsible for protecting the confidentiality of the material.

Access to performance improvement information will be limited to the Administrator, Director, Performance Improvement personnel and the Board of Directors

Policy Description:	*Number:*
EVALUATION OF PERFORMANCE IMPROVEMENT	**04.012**

PURPOSE:

To ensure the agency's performance improvement program is reviewed, revised and approved annually by the Board of Directors, Administrator and designated Performance Improvement personnel.

EVALUATION OF PERFORMANCE IMPROVEMENT:

The performance improvement program is written and maintained in order to implement the written performance improvement plan.

PROCEDURE:

The following individuals will evaluate the program annually:

1. Board of Directors
2. Administrator
3. Designated Performance Improvement personnel

The evaluation will assess:

1. The program effectiveness.
2. Whether identified problems were resolved and patient care improved.
3. The evaluation will include recommendations for improvement.
4. Coordination of other services/committees.

Policy Description:	*Number:*
PERFORMANCE IMPROVEMENT COMMITTEE	**04.013**

PURPOSE:

The purpose of this policy is to identify the potential members of the Performance Improvement committee and tasks performed.

PERFORMANCE IMPROVEMENT COMMITTEE:

Members may be the Administrator, Performance Improvement personnel and the Directors of Patient Care Services.

This committee will be able to make suggestions and recommendations regarding the problem selection, the plan of action, the monitoring and evaluation process, as well as identifying members of the team.

The Performance Improvement Committee may set the date/time for the Performance Improvement to report findings of progress, solutions/or alternate solutions to the committee and governing body

Policy Description:	Number:
PDCA MODEL FOR PROCESS IMPROVEMENT	**04.014**

PURPOSE:

The purpose of this policy is to provide guidance on the PDCA Model for process improvement.

PDCA MODEL FOR PROCESS IMPROVEMENT:

Little is new about the PDCA (Plan, Do, Check, Act) model. It merely makes explicit and conscious the steps that many people intuitively and instinctively follow when making decisions and solving problems. The PDCA model helps to move agency staff through these sometimes painful changes. To unfreeze, you acknowledge a problem or opportunity for improvement and investigate its ramifications and causes. You create a plan for improving things and take steps to gain a commitment to change on the part of staff and other powers that be. At the changing phase, you experiment, testing your proposed improvement in a trial run, closely monitoring its intended and unintended effects. Then, if you are convinced that the experiment worked and that the change is worth integrating into everyday operations, you move to the refreezing phase, in which you build in the changes and support people during what can be a disconcerting and unsettling process. At each stage of the model, there are various tools you can use either alone, with a colleague, or within a team to clarify your thoughts and decisions.

PLAN PHASE:

In this phase, focusing on one specific improvement opportunity, you need to identify inputs, outputs, customers, and suppliers; crystallize customer expectations; describe your current process; home in on problematic aspect; test theories of causes; and identify solutions. Although there is a lot to do at this stage, which tends to be very time consuming, thoroughness pay off.

Step 1: Identify Outputs, Customers and Customer Expectations

At this step, you ask questions similar to those you asked in the early steps of the customer-driven management process but with one important difference. In that process, you were asked to identify the primary customers of your department's overall functions on a macro level. However, at this stage, you are analyzing one particular process and should therefore specify the customers of that one process and the specifics about what they expect as outputs. This analysis is a micro level. You are putting the customer and professional standards of one process under the microscope so that you can improve the process, with its specific recipients and their needs in full view.

The question here relates to the process itself and what it is intended to do. You need to ask, "What are we doing (the output)? For whom (the customer)? And what does the customer expect?" For example:

- What are we doing? Producing a test result. For Whom? The physician. What does the physician expect? An accurate result quickly. Does quickly mean in minutes? In hours? In days?
- What are we doing? Completing paperwork. For whom? Medical records. What does a medical record want? A record that is legible, signed and on time.

To clarify outputs and customers, it helps to involve a staff who has a hand in the process. To identify outputs, ask: "What are all of the outputs expected of this process?" You will generally arrive at a clear picture of your outputs, which you can fine-tune even further after flowcharting. To identify customers of the process, you ask: "Who receives these outputs?"

To determine customer expectations, you need to consult the customer of the process and determine their criteria for evaluating the outputs. Do you want no errors, a courteous interchange, legible handwriting, timely output, and so forth? The output of the process needs to fulfill these criteria in order for your customer to be satisfied.

Step 2: Describe the Current Process

After you have selected a process that needs improvement, it is important to achieve a shared understanding of how the process currently works. Who are the suppliers and what are the inputs? What do we do now? What are the activities? In what order? What happens when things go wrong?

Nothing helps you to understand your current process better than flowcharting it. If you are working with a team, you can (and need to) use flowcharts to achieve a common understanding of the steps in the process that you can identify specific improvement opportunities and develop theories about causes. You cannot improve a process if you cannot visualize how the process works in the first place.

Step 3: Measure and Analyze

Once you see your current process clearly, you can decide what data to collect and how to organize them so that you can better understand the performance and dynamics of the process. For example, if your problem is that patients admitted to home health are unclear about their condition and follow-up care, you might flowchart how communication with patients currently happens on admission. The flowchart could help you to find out systematically what information is shared at each step, by whom, and with what degree of quality. Then you can check with patients at each step to find out how the problems or breakdowns occur.

The importance of flowcharting as a blueprint for beginning the measurement and analysis of your improvement opportunity cannot be overemphasized. Tools helpful at this stage for collecting and displaying data include check sheets, logs, surveys, trend charts, histograms and Pareto charts.

Step 4: Focus on an Improvement Opportunity

Within the specific process you are trying to improve, you can now home in on one improvement you want to make or one problem you want to solve. You can use multi-voting, decision matrices, and Pareto charts to help focus all the possibilities. For example, if you selected chart completion as a process that needs improvement, you might then focus your improvement efforts on the particular step in the process at which information might from labs is entered on the chart.

Focusing on a specific step in the process you have identified for improvement is essential to your improvement efforts. Many teams waste vast amounts of time because team members work at cross-purposes on different understandings of the problem. One clear, specific statement of the problem must be developed.

A good problem statement does a number of things. First, it states the effect that is unsatisfying rather than theorizing about causes or implied solution. It says what's wrong, avoiding such language as lack of, due to, and we should. It is simply a statement of the problem. Example of some statements which implies solutions include:

- How to increase staff so patients do not have to wait so long to be seen.
- How to double-check that medication profiles are updated on a continual daily basis.

Examples of some clear problem statements are the following:

- How to reduce patient waiting time for visits.
- How to reduce the number of medication profiles not updated appropriately.

Second, a good problem statement:

- Focuses on the gap between current and desired reality.
- Is measurable; states when and how much.
- Is specific and tangible; uses concrete words, not vague concepts that mean different things to different people (such as morale, communication, trust, attitudes).
- Pinpoints the pain; emphasizes how customers, employees, and/or the organization are affected by the problem (for example, dissatisfaction levels, complaints generated, money wasted, and so forth).

To arrive at a good problem statement, it helps to generate many possible alternatives and then consciously choose one that is agreeable to everyone. A worksheet similar to the one shown below could be used in the process.

- What are the symptoms of the problem?
- What's the problem (not the solution)?

Team members compare notes about the symptoms of the problem and then generate alternative statements of the problem. They then discuss the alternatives and decide which problem statement they want to address so that everyone has the same focus. This process is helpful because many problems are multidimensional. For example, consider a problem first identified as a "morale problem." Trying to generate solutions without first establishing a clear focus would lead the team members in many different directions. However, answering questions such as the following on the worksheet would enable everyone to focus on the same problem:

- What are the symptoms of this moral problem?
  - We're losing talented staff.
  - People are grouchy and constantly complain.
  - We're hearing more complaints from patients than usual.
  - Unhappy staff people are dragging down their co-workers.
- Statements of the problem: The problem as I see it is...
  - How to increase retention of good people.
  - How to improve the quality of our work life so that people aren't feeling so negative.
  - How to reduce the number of complaints from patients about our people.
  - How to increase the satisfaction level of our staff.

As you can see, investigation of the problem and identification of solutions can be very different. In this case, it is clear that if the team skipped the step of selecting one problem statement, each member might be working with a different understanding of the problem, which would result in misunderstanding and confusion.

Step 5: Identify Root Cause

Once you've charted and analyzed your process and defined the specific problem, you need to generate and test theories. Most problems have more than one cause, but some causes have a more powerful impact on the problem than others. These are the root causes. Treating a root cause can reduce your problem significantly, whereas treating an "apparent" cause may do no more than relieve symptoms that eventually recur or reappear in some other form.

For example, patients may be frustrated by long waits for AM visits. You cannot really resolve this problem unless you know why they are waiting so long. Is some staff out sick? Is the scheduling system ineffective? Are patient charts not found? Or some combination thereof? Any one of these facts might be a root cause of the long delays. Once you identify the root cause, you can design an enduring process improvement.

Three steps are helpful in identifying root causes:

1. Generate theories of causes.
2. Test these theories by gathering more data.
3. Pinpoint the cause(s) having the greatest impact on the problem.

For example, let's say patients and their family members think that the home health instructions are confusing and incomplete. Using a cause-and-effect diagram and brainstorming, a work group or a team can identify the possible cause of this complaint. Causes may include:

- Pamphlets relevant to specific conditions are not being consistently distributed to patients and their families.
- Patients and their family members who read the pamphlets do not find the information helpful.
- Some patients and their family members feel clear about instruction at the time of the visit but by the time the nurse leaves they forgot them.

Theses are theories about causes. Once you have generated theories, you usually need to gather data to test them. In the preceding example, you might briefly interview patients to determine how well they understand the instructions and then later telephone them at home to see whether they have retained their understanding. That would test your theory that patients and their families feel clear about instructions at the time of the visit but forgot them by the time the nurse leaves. And to test your theories about the distribution and value of the pamphlets related to specific conditions, you could follow up with a sample of patients to find out whether they received the appropriate pamphlet. The second phase of this follow-up would be to determine whether they read it. You could also ask them to read the pamphlet and evaluate the helpfulness of the information.

You can usually test your theories by simply asking, "How can we find out whether this is a cause of our problem?" Interview with customers, observations of steps in a process, and discussion with other staff involved in the process can be helpful methods of testing your theories about causes.

You can then focus in on the one or two causes that exert the greatest impact on your desired results. This may be determined by listening to the people directly involved or examining the results of testing your theories and asking, "What does this say to us?" In the previous example, if patients read and understood the pamphlet but disregarded what it said because, "I do what my doctor tells me", the

pamphlet is not the cause with the greatest impact. You need to help the physician give the pamphlet credibility in the patient's eyes.

In some instances, you might select the cause with greatest impact by using a quantitative method, such as a Pareto chart. For example, if your were investigating the root cause of long delays, you could measure the time involved in each step of the process and determine the step or steps at which the longest delays occur.

Many simple tools are available to help you pursue all three steps in this cause identification process. To generate theories about causes, brainstorming and the cause-and-effect diagrams, are especially helpful. Test your theories by collecting data through check sheets, logs, surveys, focus groups, interviews and histograms. Then, use Pareto charts to select the root causes from among the several possible causes.

Step 6: Generate and Choose Solutions

It is now time to think of solutions, preferably an array of possibilities. If you select one solution before you've generated alternatives, you often settle prematurely for the obvious and familiar in lieu of the powerful or creative. When working with a group, you need to set a tone that encourages creativity and wild-eyed possibilities and bans phrases and gestures that stifle the flow of ideas. In other words, there are innumerable possibilities that can be tapped if you create an atmosphere that encourages creative and uninhibited thinking and speculation about how things can be done better.

Helpful tools at this point include focus groups with customers and suppliers, discussions with the staff involved, affinity charts and brainstorming. Then, focus groups, interviews with staff and decisions matrices help in selecting the most promising solutions from among the many.

DO PHASE:

At this phase, you plan and enact your pilot. To begin with, you need an "experimenter" mind-set. As yet, you do not have a solution; rather, you have proposed solutions, a well-researched hunch that now needs to be tested.

Step 7: Map Out a Trial Run

What may appear to be an exciting and brilliant solution may turn out to be off the mark. Therefore, you must take the pains necessary to execute it effectively and evaluate its worth. You need to secure whatever financial, technical and human resources necessary for a trial run, and you need to involve the right people in accepting the idea and doing their part to implement it. That is why you must have a plan of action that includes implementation steps that indicate who is responsible at each step and by when, how implementation will be monitored, and how and when results will be verified.

Step 8: Implement the Trial Run

Even after you have devised a great implementation plan, your work is not over. Often people conclude that an experiment did not work when, in fact, it was never implemented as planned. Because you are introducing change and because old habits (processes) are difficult to change, you need to build monitoring and controls around your implementation process so that you know that what is suppose to be happening is actually happening. You cannot say the pilot failed if it was not thoroughly tested. Thus, when you implement the trial run, be sure to meet periodically with key players and observe and chart the process to ensure that implementation is conforming to plan.

CHECK PHASE:

Once your experiment is in place, you need to monitor performance to evaluate results and determine the extent to which the changes are indeed making things better.

Step 9: Evaluate Results

Consult your process and outcome indicators to verify the effectiveness of your experiment. Control charts, trend charts, checklist, logs, check sheets and simple observations are useful for this purpose. To understand the effects on internal and external customers perceptions, surveys, focus groups and interviews are especially useful.

Step 10: Draw Conclusions

With evaluation results in hand, you're ready to make one of the three decisions:

1. The results look promising, but we have to fine-tune the changes.
2. Our pilot failed; we need to go back to the drawing board and generate other possible solutions.
3. It worked. Now it's time for us to make it routine!

Questions that help are:

- Did your change indeed produce improved performance?
- What are the cost and benefits of the improvement?
- Does it make sense to alter the everyday process to incorporate the changes made to hold the gains?
- If so, what needs to be done to change the process?
- What modifications need to be standardized and how can people, material, equipment and schedules be equipped to make the transition?

ACT PHASE:

At this stage, you do what is needed to integrate positive changes into everyday work processes so that your gains persist over the long haul (or until you make further improvements).

Step 11: Standardize the Change

Tasks at this stage include:

1. Draw a revised flowchart and clearly show the re-vamped process as it should work from now on.
2. Consider other areas in which the solution might beneficially be applied. Consult the people involved and determine the scope of the standardization process.
3. Modify standards, procedures, policies, and performance expectations to reflect the changes process.
4. Communicate the changes to the employee, customer and suppliers involved.
5. Train as needed.
6. Develop a clear path for supporting people throughout the change process; provide a supportive

environment, create clear channels for reviewing snags and frustrations and acknowledge and recognize changes in behavior early on.

7. Document the project; circulating its evaluation or story (perhaps using a storyboard) to senior management, other department managers, the people who worked on the solution, other team leaders or facilitators who can learn from your experience and the frontline people who will actually do the changed process in the future.

Caution: People often lose steam during this phase of the process and feel as though their job is done. As a result, they may not be as methodical or persistent in standardizing their changes as they need to be. It is true that the suspenseful, exciting phase of the detective work and problem solving are, for the moment, done. However, if you don't keep a tight rein on the process of internalizing your changes into everyday work, the gains will be lost. Your situation will regress to its former level despite the hours, days and sometimes months spent correcting it. At this stage, you need to plan, document, communicate, train and monitor. Helpful tools include:

- Brainstorming sessions to discuss the steps involved in standardizing the process.
- Flowcharts of the new process that can be used to orient and train staff to follow the process.
- Clear, written instructions for specific steps in the process.
- A troubleshooter's guide explaining what problems might be anticipated and how staff might handle them.
- Training guides and opportunities followed by one-on-one coaching.
- Implementation planning tools.

Step 12: Monitor to Hold the Gains

To ensure that the changes stick, you need to continue a regular schedule of measurement and process control. Scatter diagrams, checklist and run charts can help you monitor performance regularly at critical control points and comparatively over time. Without such tools, hard-won changes often disappear because old habits die hard.

THE MODEL AS A GUIDE:

You may be thinking: "So many steps! So much to do! So complex!" Although we propose the preceding as a rational and sequential process, it is meant only as a blueprint or guide and not as a model to be followed lockstep. Our intention is not to make the improvement process tedious, nor is it to "program" you. As you proceed through the steps involved, you may find that you can skip certain steps because you already know the answers they will yield. However, be sure your answers are based on fact and not on opinion.

CONCLUSION:

By making the implicit explicit and the unconscious conscious, you can gain control over your approach and decide what you need to do to pursue an improvement opportunity constructively, just as a flowchart creates new possibilities for controlling and improving work processes, our model for process improvement, which is itself a flowchart, creates new possibilities for controlling and improving your effectiveness at process improvement.

BUILDING CONSENSUS:

Consensus means finding a proposal acceptable enough that all members of the group can support it, i.e., no one opposes it.

Consensus is not:

- A unanimous vote, i.e., a consensus may not represent the first priority of everyone.
- A majority vote. In a majority vote, only the majority get something they are happy with; people in the minority may get something they don't want at all, which is not what consensus is all about.
- Consensus is finding a proposal that is acceptable to all; this does not mean everyone gets his or her priority.

BRAINSTORMING:

Brainstorming is a method of eliciting a large number of ideas from a group of people in a short period of time.

Rules for brainstorming:

- Make sure that all team members fully understand the objective of the brainstorming session.
- Encourage active participation of all members.
- The more ideas the better! Everyone freewheel it.
- Develop a high energy, enthusiastic climate.
- Record all ideas exactly as presented on a flipchart, possibly using two recorders.
- No discussion during the brainstorming.
- No criticizing, groaning, or making fun of other people's ideas.
- Avoid stopping when the ideas slow down; rather try to generate as long a list as possible.
- Members take turns shouting out ideas.
- It's fine to *hitchhike*, or build on someone else's ideas.
- All ideas are displayed for everyone to see.
- Members pass when an idea does not come to mind quickly.

NORMAL GROUP TECHNIQUE:

Purpose:

The nominal group technique is a structured brainstorming technique. (More structured than free flow.)

When To Use:

To generate a list of options and narrow it down or prioritize the list. (It is called "nominal;" because the group doesn't spend as much time in discussion or interaction.)

It is an effective tool for controversial issues or use when a team is in disagreement. It is also a good tool to use when "powerful" people are present.

Guidelines:

Part 1, Formalized Brainstorming:

1. Define the task in the form of a question; e.g., "What are ways we can improve our library service to students?"
2. Describe the purpose of the discussion and rules and procedures for this technique.
3. Introduce and clarify the questions.
4. Generate ideas. Have team members write down their response in silence. Do not allow any distraction.
5. List ideas. When everyone is done, have each participant read one idea from his/her list. (For greater confidentiality, cards should be collected and the leader read one response at a time. Someone other than the leader may record theses responses.) Write every answer on a flipchart. Continue the round robin until everyone's list is complete or you run out of time (usually no more than 30 minutes). No discussion or clarification is allowed at this point.
6. Clarify and discuss ideas. Display all the flipchart pages in full view of the entire group. The facilitator asks if anyone has questions about any item listed. The person who contributed should be the one to answer a question. The facilitator may choose to change the wording, but only when the person who originally proposed the idea agrees.
7. When there are no more questions, the facilitator condenses the list as much as possible. If the originators of the ideas give their approval, combine ideas.

Part 2, Making Selections:

1. If there are 50 or more items, use some method to reduce the list to 50 or fewer items. (Use multi-voting, or let members withdraw the less serious items.)
2. Give each participant from 4 to 8 index cards. The number of the cards is a rough fraction of the number of items still on the list. Hand out 4 cards a piece for up to 20 items; 6 cards for 20 to 35 items; 8 cards for 35 to 50 items.
3. Members individually make their selection from the list. They write down one item per card, one card per item (4, 6 or 8 depending on how many cards they have).
4. Have members assign a point value to each item, based on their preference. Each person assigns the highest point value to the most important item. The value depends on the number of items selected. In an 8 card system, the most preferred item is numbered 8; the second most preferred item is numbered 7 and so on.
5. After each participant has given point values to the items selected, the cards are collected and the votes tallied. It is easiest to mark the flipchart page with the original list, noting the value of each vote an item received, then adding up the values. The item that ends up with the highest point total is the group's selection or priority.
6. The group reviews results and may display results on a pareto diagram to see which received the most votes, and which received highest totals.

AFFINITY DIAGRAM:

Purpose:

A group decision-making technique designed for a large number of ideas, process variables, concepts and opinions into naturally related groups. These groups are connected by a simple concept.

When To Use:

Use is to sort a list of ideas into groups.

Guidelines:

1. Insure ideas are described with phrases or sentences.
2. Minimize the discussion while sorting -- discuss while developing the header cards.
3. Aim for 5 - 10 groups.
4. If one group is much larger than others, consider splitting it.

How To Conduct An Affinity Sort:

1. Clarify the list of ideas. Record them on small cards.
2. Randomly lay out cards on table, flipchart, wall, etc.
3. Sort the cards into "similar" groups in silence -- based on your gut reaction. If you don't like the placement of a particular card -- move it. Continue until consensus is reached.
4. Create header cards consisting of a concise 3 - 5 word phases, description, and the unifying concept for the group. Then, place the header card at top of group.
5. Discuss the groupings and try to understand how the groups relate to each other.

FLOWCHARTS:

Purpose:

Flowcharts are picture summaries of the operations in a process, and should be used on every process.

When To Use:

Use is to plan stages of a project or describe a process being studied. They outline sequences of actions; provide teams with common reference points and standard language. Flowcharts can be helpful when describing the steps in a new process or improved system.

How To Use Top-Down Flowcharts:

Top-down flowcharts show the major steps in a process. They are useful in limiting the amount of information, because people must narrow their ideas to only essential steps in a process. Teams spend time looking at the whole process and not worrying about details.

1. List the major steps in a process (ideally not more than five).
2. List the steps in blocks across the top of a flipchart.
3. Below each step, list the major sub-steps (ideally not more than six or seven).

How To Use Detailed Flowcharts:

The systems or detail flowcharts pictorially represent each of the operations in a process. It is used when more detail is needed to understand where problems arise.

1. Involve people who know the process thoroughly.
2. Construct the flipchart as the process actually happen, not the way it "should" happen.
3. Define the boundaries of the process.
4. Describe each step, in the order it happens, using single-verb description.
5. Draw a line to connect each step to the next step that follows.
6. Use standard flowcharting symbols.

Detailed Flowchart Tips:

- For efficiency in a process, seek to eliminate the **"NO"** side of the chart.
- Special causes sometimes can be identified on the **"NO"** side.
- Always seek input from the people who actually do the process.
- Avoid the temptation to correct a process as you chart it.

CHECK SHEET:

Purpose:

The purpose is to provide quantitative evidence of the frequency of events (complaints, telephone calls, problems). It can be used to determine if something team members suppose is a problem indeed is a problem.

A check sheet is an easily understood form to answer the questions, "How often are certain things happening?" The check sheet is the initial step in translating *opinions* into facts.

How To Construct:

1. Agree as to the event being observed. What does the data being collected represent?
2. Determine the time frame to be used in collecting the data (hours, days, weeks).
3. Design a clearly understood and easy-to-use form. Be careful to label accurately all columns and provide ample space for entering data.
4. Collect the data consistently. Time gaps will nullify reliability.
5. Provide sufficient time for the data collecting task.

Tips about Check Sheets:

- Make sure observations and samples are as representative as possible.
- Make sure the data collection method is simple so people have time to collect accurate data.
- Data must be from homogenous groups (for example, machines, persons, situations. It may be necessary to separate categories to gather data on one category at a time.
- Use existing form for data collection whenever possible. For instance, collect data on a copy of

the form itself for errors made in completing the form.

- Keep separate check sheets for different categories checked so that differences in time, sequence or personnel may be apparent.
- Operational definitions should be understood by all collecting data. Be very specific.
- Data collected should relate to key quality characteristics.
- Construct an operational definition of each category to ensure data collected is consistent.

WRITING OPERATIONAL DEFINITIONS:

Write an operational definition for collecting data on this part of the process. The following questions may be used to provide guidance:

- What is the overall process to be improved?
- What are the key quality characteristics of the customer in this process?
- What represents a defect in the process?
- What part of the process will be observed for effectiveness?
- What is the input in this part of the process?
- What is the supplier of this part of the process?
- What is the customer of this part of the process?
- What represents a defect in this part of the process?
- How will you know there is an improvement?
- What is the time frame for collecting the data?
- Who will collect the data?

RUN CHART (also known as Trend Chart):

Purpose:

The run chart graphically displays data over a time.

When To Use:

Use the run chart to display simple trends over a specified time period.

Guidelines:

1. Collect data over a period of time.
2. Label vertical axis with the unit of measurement for the value point. (For example, number of complaints).
3. Label horizontal axis with the time sequence for data points. (For example, days, and weeks.)
4. Scale the vertical axis. (A rule of thumb is to calculate a starting value 20% less than the lowest point and an ending value 20% greater than the highest point.)
5. Plot the intersecting points corresponding to value and time.

6. Connect points with a line.
7. Determine the median and display it as a line on the run chart. (Median is the middle value if the data points are ordered from low to high. If it is an even number of values, the median is the average of the two values.)

Tips on Using a Run Chart:

- Resist the temptation to react to every variation.
- The value of a run chart is to display trends.
- Special cause may be suspected if there are too many or too few runs about the median for a given number of data points; seven consecutive points are increasing and decreasing; and/or eight or more consecutive points are on the same side of the median.
- For validity, 15 - 18 points are needed for interpretation.
- If special cause variation exist and is desirable, seek to identify and learn from it. If it is undesirable, seek to identify and prevent its reoccurrence.

TYPES OF VARIATION:

Common Cause Variation:

- The variation is due to the process.
- It is produced by interactions of variables in the process.
- This collection of variables and their interaction is called the system of common causes.
- Management may assign teams consisting of internal suppliers, the owners of the process, customers and others who can contribute knowledge about the common cause.

Special Cause Variation:

- Variation in the process that is assignable to a specific cause or causes.
- This variation arises because of special circumstances.
- An individual worker may work on this source of variation, or management may assign a team to work on removing special causes, but its composition will likely be different from a team working on reducing common cause variation.

CONTROL CHARTS (same as Run Chart but has upper and lower control and median range):

Purpose:

Walter Shewhart was the first person to give a simple and effective way to define the *voice of a process.* He called it a *control chart.* Control charts monitor the on-going performance of a process. They can help study process capability, detect changes in process average and variability, and help define quality objectives. A control chart identifies the extent of variation in a process.

"A control chart begins with a time series graph. A central line (mean or average) is added as a visual reference for detecting shifts or trends, and control limits (computed from the data) are placed equidistant on either side of the central line. Thus, a control chart is simply a time series with three horizontal lines added."

A control chart is a run chart plotted with statistically determined upper and lower control limits, and a mean (average) line.

Types of Control Charts:

Variable Control Charts - used with things which can be measured (e.g., length, weight, time).

- Attribute Control Charts - used with things that can be counted. Generally we think of attributes as reflecting quality (e.g., rejections, acceptable/unacceptable, complaints).

Guidelines:

You should have 30 data points to review but may not have time depending on importance of data.

1. Construct the run chart according to run chart guidelines.
2. Select the appropriate control chart.
3. Find the mean (average), the upper (UCL) and lower (LCL) control limits using the appropriate formula.
4. Chart lines for mean, UCL and LCL.
5. Identify special causes (outside control limits) and take appropriate action to eliminate or learn from them.
6. Begin PDCA to improve common cause variation.

Tips On Using Control Charts:

- Special causes must be eliminated before improving a process.
- When all data points are within control limits and no apparent patterns exist, improvement will happen only by improving a process.
- Do not react to individual variation when a process is in control. This is tampering and will result in greater variation.
- Monitoring for improvement is possible with common cause variation only.
- When special causes can be explained, remove these points from the calculation, but leave the points on the chart.
- If special causes cannot be explained, begin PDCA to eliminate these causes before attempting to improve the process.
- As with the run chart, time intervals should be constant and of the same value/duration.

CAUSE AND EFFECT DIAGRAM (or Ishikawa Diagram or Fishbone Chart)

Purpose:

The *cause-and-effect* diagram shows the relationship between a problem and it's possible causes. It helps analyze cause and effect relationships. It may help you find where you want to collect data.

When To Use:

1. To illustrate what data should be collected to isolate the reason for the problem.

2. To show the relationships among many possible causes.

Guidelines:

1. Select a problem within your work area. Describe the problem in a statement that includes, specifically when the problem occurs, what happens, and the extent and frequency of the problem.
2. Use brainstorming; identify all the possible causes of the problem.
3. List the effect, or problem, on the right of the chart.
4. List the causes on the left side of the chart using the "bones" of the fish. Major causes are summarized under broad categories such as Materials, Manpower, Methods and Machines - or - People, Policies, Procedures, Plant.
5. For each cause, ask, "Why does it happen?" List the responses as branches off major causes. Ask why 5 times to see if you can get to the root of the problem.
6. To interpret the diagram, find the most basic cause of the problem.
7. Look for the causes that appear repeatedly.
8. Reach a team consensus.
9. Gather data to determine the relative frequency of different causes.

Tips:

- Take care to identify causes rather than symptoms.
- Post diagrams to stimulate thinking and get input from other staff.
- Self-adhesive notes can be used to construct an Ishikawa diagram.
- Sources of variation can be rearranged to reflect appropriate categories with minimal rework.
- Insure that the ideas placed on the Ishikawa diagram are process variables, not special causes, other key quality characteristics, tampering, etc.
- Review the quick fixes and rephrase them, if possible, so that they are process variables.

PARETO DIAGRAM:

Purpose:

The *Pareto Diagram* is based on the Pareto principle, which states that just a few of the causes often account for the most of the effect. The diagram displays, in decreasing order, the relative contribution of each cause to the total problem. It ranks causes from most to least significant.

When To Use:

1. To illustrate data collected and to direct our attention and efforts to the truly important problems.
2. To show the relative importance of the problems or conditions.
3. To choose a starting point for problem solving, monitor success, or identify the basic cause of a problem.

Guidelines:

1. Select the problems to be compared or rank ordered.
2. Select the standard unit of measurement for comparison such as annual cost, frequency, etc.
3. Select the time period to be analyzed.
4. Gather necessary data on the site of each category. For example, "This defect happened 21 times in the last six months."
5. Compare the frequency or cost of each category to all other categories.
6. List the problems or categories from left to right on the horizontal axis in the order of decreasing frequency or cost. You can combine the categories containing the fewest items into an "other" category. Place this category at the extreme right, as the last bar in the diagram.
7. Above each classification, draw a rectangle whose height represents the frequency or cost in that classification. If you record raw data on the left vertical axis with a percentage scale on the right axis, be sure that the two axis are drawn to scale. For example, 100 percent should be opposite the total frequency or cost and 50 percent should be opposite the halfway point in the raw data.
8. To help interpret the chart, draw a line from the top of the tallest bar, moving upward from left to right. This line is drawn through points corresponding to the cumulative percentage of each category and shows the cumulative frequency of the categories.

PARETO CHART:

Purpose:

A bar graph is used to arrange information in such a way that priorities for process improvement can be established.

When to Use:

1. To display the relative importance of data.
2. To direct efforts to the biggest improvement opportunity by highlighting the vital few in contrasts to the useful many.

Guidelines:

1. Determine the categories and the units for comparison of the data, such as frequency, cost or time.
2. Total the raw data in each category, then determine the grand total by adding totals of each category.
3. Re-order the categories from largest to smallest.
4. Determine the cumulative percent of each category, *(the sum of each category plus all categories that precede it in the rank order, divided by the grand total and multiplied by 100.)*
5. Draw and label the left-hand vertical axis with the unit of comparison, such as frequency, cost or time.
6. Draw and label the horizontal axis with the categories. List from left to right in rank order.

7. Draw and label the right vertical axis from 0 to 100 percent. The 100 percent should line up with the grand total on the left-hand vertical axis.
8. Beginning with the largest category, draw in bars for each category representing the total as measured on the left-hand axis.
9. Draw a line graph beginning at the right-hand corner of the first bar to represent the cumulative percent of the total.

Tips:

- Create before and after comparisons of Pareto charts to show impact of improvement efforts.
- Construct Pareto charts using different measurement scales, frequency, cost or time.
- Pareto charts are useful displays of data for presentations.
- Use objective data to perform Pareto analysis rather than team member's opinions.
- If the data does not indicate a clear distinction among the categories - if all bars are roughly the same height or half of the categories are required to account for 60 percent of the effect - consider organizing the data in a different manner and repeating Pareto analysis.
- Pareto analysis is most effective when a key quality characteristic is defined in terms of shrinking the performance value to a customer target.

Policy Description:	*Number:*
TRAINING AND ORIENTATION	**02.008**

PURPOSE:

The purpose of this policy is to establish the Agency's guidelines on training and orientation.

TRAINING AND ORIENTATION:

Training and orientation are provided for all employees prior to assuming their duties and/or patient care responsibilities. Orientation will be provided on site or off site as appropriate. Orientation to each case is based on assigned responsibilities and individual patient needs. Each employee shall undergo training specific to their position which may include:

- Explanation of the Agency services philosophy, purpose, goals and objectives.
- Job description review (duties and responsibilities).
- Organizational chart and supervisor.
- Field staff introduction.
- Appropriate organizational policies and procedures.
- Care delivery in the home setting.
- Patient care policies and procedures.
- Confidentiality of patient information.
- Patient and/or family's rights.
- Appropriate actions in unsafe situations.
- Ethical considerations.
- Field experience and/or practical experience under supervision.
- Curriculum content for the home health aides.
- Type of services to be provided.
- Special care requirements.
- Care of patients across the Life Span.
- Reactions to stress.
- Personal care needs.
- Physical and emotional reactions to aging.
- Agency's disaster plan.
- Emotional and physical needs.
- Available community services/resources.
- Reactions to illness.
- Basic health needs and health needs by disease type.
- Recognizing changes in condition that need reporting.

- Concepts of mental illness.
- General care needs.
- Physical and emotional needs.
- Issues on death and dying.
- Do not resuscitate policy.
- Death at home policies.
- Pain and symptom management.
- Basic psychosocial issues on dying.
- Role, responsibilities and needs of the primary caregiver and/or family dynamics.
- Communication skills (listening and talking).
- Hearing impaired.
- Care of Alzheimer's patients.
- Observation, reporting and documentation of client/patient condition.
- Equipment management including the safe and appropriate use of equipment.
- Maintenance of a clean, safe and healthy environment.
- Home safety (bathroom, fire, environmental, electrical and medication safety).
- Value of housekeeping.
- Staff responsibilities.
- Guidelines for cleaning a house, washing dishes, managing home laundry.
- Maintenance of clothing.
- Sensitivity to values and lifestyles.
- Infection control and safety management.
- Universal precautions and Exposure Control Plan.
- Identification handling and appropriate disposal of hazardous or infectious waste (dressings, needles, body fluids, tubings, drugs, gloves, etc.).
- Cleanliness of supplies/equipment.
- Special precautions for AIDS and other infectious diseases.
- Cleanliness of uniforms or clothes
- Special precautions in the event of infectious diseases such as colds/flu.
- Storage, handling, delivery and access to supplies (dressings, catheters, etc.); medical gases (oxygen); and drugs (chemotherapeutic agents, controlled substances).
- Nutrition and food preparation.

- Nutritional needs of patients (infants, children, and elderly).
- Modified diets and/or diet restrictions.
- Feeding techniques.
- Use of assistive devices.
- Safe transfer and ambulation techniques.
- Proper body mechanics.
- Special techniques and precautions.
- Methods to assist patient to achieve maximum self-reliance.
- Obtaining vital signs.
- Changing or applying dressings, ointments and topical medicines.
- Handling cytotoxic agents.
- Drug/product dispensing and distribution.
- Special exercises and treatments.

Orientation will be as necessary and as determined by the supervisor. Each employee shall demonstrate competence for their position when necessary.

It is acceptable to use consenting employees of the Agency for the purpose of demonstrating, training and/or determining competency for the performance of non-invasive procedures. However, in no instance will it be acceptable to use any employee of the Agency as a 'live model' for the purpose of demonstrating, training or determining competency for the performance of any invasive procedure.

All employees shall receive a copy of the employee handbook.

Evidence that the employee has been through orientation and appropriate training and is aware of applicable personnel policies and position requirements shall be maintained in the personnel file.

Policy Description:	*Number:*
IN-SERVICE AND CONTINUING EDUCATION	**02.009**

PURPOSE:

The purpose of this policy is to establish the guidelines for in-service and continuing education.

IN-SERVICE AND CONTINUING EDUCATION:

The in-service training or continuing education programs available shall be based on identified needs such as changes in care/service(s) including new therapy modalities, equipment and/or new programs. In-service or continuing education programs shall also be based on the staff's need for knowledge.

Continuing education and/or in-service training appropriate to the individual's responsibilities and to the maintenance of skills necessary for the care of patients will be assessed and provided when necessary. Additionally, continuing education and/or in-service training required for individual licensure requirements must be met per applicable Federal, State and/or local regulations.

Requirements for Home Health Aides and Certified Nurse Technician Assistants:

Each home health aide and certified nurse technician/assistant must receive at least 12 hours of in-service training per year. Supporting documentation of previous in-services may be included in meeting the annual 12 hours of in-service requirement. The in-service training may be furnished while the aide is furnishing care to patients.

Evidence of staff attendance at in-service training and/or continuing education programs shall be documented on in-service attendance logs, certificates of attendance, and/or in the personnel file. This documentation should also include an outline and/or summary of the in-service training and/or continuing education program.

Attachment Section C, Contribution to the Orderly Development of Health Care

Item 6

Policy Description:	Number:
Student Precepting Program	**02.015**

PURPOSE:

The purpose of this policy is to provide guidelines for clinical experience within the affiliate agency for students enrolled in professional programs.

PROGRAM GUIDELINES:

A clinical affiliation contract will be established between the institution the student is enrolled and that affiliate agency with the following terms and provisions.

1. Students are subject to applicable policies of the agency while enrolled in the clinical experience.
2. Neither party shall be responsible for personal injury or property damage or loss except that resulting from its own negligence or the negligence of its employees.
3. Health records and insurance statement that: The institution will provide health records of students on request of the agency (affiliate). The affiliate requires written evidence of professional liability insurance coverage from individual students participating in the experience. The minimum amount of coverage per individual shall be $2M/4M.
4. Background check statement: Background checks will be provided on each student by the institution the student is enrolled.
5. HIPPA compliance statement that: Each party will comply with the Health Insurance Portability and Accountability Act of 1996.
6. A statement that: The agreements do not provide for monetary compensation to either institution, the other party or any student.
7. A statement that: Each party will comply with all federal, state, and municipal laws, advice, rules and regulations which include statements that are applicable to the performance of this agreement.
8. The duration of the agreement should be at least one year with a provision to terminate the agreement upon giving a 30 day written notice to the other party.
9. A statement that: The affiliate may immediately remove from the facility any student who poses an immediate threat or danger.
10. A statement that the parties agree to comply with Titles VI and VII of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 and Section 504 of the Rehabilitation Act of 1973, Executive order 11, 246, the Americans with Disabilities Act of 1990 and the related regulations to each. Each party assures that it will not discriminate against any individual including, but not limited to, employees or applicants for employment and/or students because of race, religion, creed, color, sex, age, disability, veteran status or national origin.

Specific responsibilities of the designated party:

1. Institution shall be responsible for the educational program of students assigned to the Agency, and for selections, evaluation, and assignment of students in accordance with agreed upon schedule.
2. Institution shall supply to the Agency in writing the names of students prior to their participation in the program at the Agency.

(148)

3. Agency shall provide orientation to the facility for students beginning clinical experience.
4. Agency shall retain complete responsibility for patient care providing adequate supervision of students at all times.
5. Agency shall provide emergency medical treatment to students if needed for illness or injuries suffered during clinical experience. Such treatment shall be at the expense of the individual treated.
6. Confidentiality of patient records and student records shall be maintained at all times.
7. Students are responsible for being at assigned agencies at times scheduled.
8. Students are to adhere to any uniform or dress regulations required by Agency.
9. Students will be required to sign a Statement of Confidentiality, a release from liability statement, and agreement to abide by the contract provisions prior to the preceptor experience.

(149)

STUDENT AGREEMENT

Understanding that the experience at CareAll Home Care requires traveling with an employee of the agency, I agree:

1. that no legal action in excess of private liability coverage will be taken against any employee of CareAll Home Care in case of injury (physical or mental) as a result of traveling with an employee of the home health care agency.
2. to abide by the agreement between _____ and CareAll Home Care.

Signature:_____ Date: _____

Witness Signature: _____ Date: _____

(150)

Attachment Section C, Contribution to the Orderly Development of Health Care

Item 7, a.

Policy Description:	*Number:*
REGULATORY REQUIREMENTS	**01.009**

PURPOSE:

The purpose of this policy is to outline the Agency's compliance with all regulatory requirements.

REGULATORY REQUIREMENTS:

Compliance:

The Agency maintains compliance with all applicable local, state, and federal laws and regulations. Where required by state or local statutes, the Agency and staff maintain licenses in accordance with applicable regulations for such licenses. The Agency shall also take appropriate action on reports and recommendations of any authorized planning, regulatory and/or inspection agency.

Professional Practice Acts:

The Agency provides health care services in accordance with recognized standards of professional practice and with applicable statutes and regulations controlling the practice of the disciplines providing the services.

The Agency shall function in accordance with state and federal laws. Duties assigned to staff will be in compliance with limitations imposed by the state practice act.

The Agency will maintain contact with the applicable state boards regulating the services provided by the Agency to clarify the contents of practice acts as they relate to the services provided by the Agency. Copies of applicable practice acts will be available to Agency staff.

Agency Licensure:

The Agency will comply with Federal and/or State Regulations and maintain licensure as a home health Agency in the state and will comply with such additional requirements as may be dictated by regulation. Reports of Agency services, statistics, changes and other required information will be provided as stipulated.

Certification:

The Agency if providing Home Health Medicare covered services, will maintain current certification as provided in the conditions of participation for the Medicare program.

Attachment Section C, Contribution to the Orderly Development of Health Care

Item 7, c.

(154)

Board for Licensing Health Care Facilities

State of Tennessee License No. 0000000288

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

PROFESSIONAL HOME HEALTH CARE,LLC *to conduct and maintain a*

Home Care Organization CAREALL HOMECARE SERVICES

Located at 901 HWY 51 SOUTH, COVINGTON

County of TIPTON *, Tennessee.*

This license shall expire JANUARY 22 , 2014 , *and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 22ND *day of* JANUARY , 2013 .

In the Distinct Category(ies) of:

SKILLED NURSING
PHYSICAL THERAPY
OCCUPATIONAL THERAPY
SPEECH THERAPY
MEDICAL SOCIAL SERVICES
HOME HEALTH AID SERVICES
MEDICAL SUPPLIES & APPLIANCES
HOMEMAKERS SERVICES
HOME HEALTH AGENCY
OTHER SPECIALTY

By Vincent J. Dawson, MPH
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By John J. Dreyzehner MD
COMMISSIONER

Palmetto GBA

A/B MAC Jurisdiction 11

May 2, 2012

PROFESSIONAL HOME HEALTH CARE LLC
CARE ALL HOMECARE SERVICES
ATTN: James Carell
901 Hwy 51 South
Covington, TN 38019

DCN: 12053023100016

We have processed your Medicare enrollment application*(s)* to revalidate your Medicare enrollment information. The revalidation was completed for the following entity.

Legal Business Name:	PROFESSIONAL HOME HEALTH CARE LLC
DBA:	CARE ALL HOMECARE SERVICES
NPI(s):	1194780569
PTAN/CCN:	447503

In addition, to revalidating the above provider number information, the following updates were completed.

- ☐ Name Change
- ☐ Structure Change
- ☐ Practice Special Payment Address
- ☒ Management Personnel Addition Melissa Paris effective: 11/14/2011
- ☒ Management Personnel Deletion Sue Permenter effective date:11/01/2011
- ☐ Telephone Number
- ☐ Fax Number
- ☐ Branch Location
- ☐ Authorized/Delegated Official
- ☐
- ☐ N/A

Please verify the accuracy of your enrollment information. If you disagree with any portion of this initial determination, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The request for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. The reconsideration request must be signed and dated by the physician, non-physician practitioner or any responsible authorized or delegated official within the entity. Failure to timely request a reconsideration

is deemed a waiver of all rights to further administrative review. The request for reconsideration should be sent to:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment Operations Group
7500 Security Blvd.
Mailstop: AR-18-50
Baltimore, MD 21244-1850

To maintain an active enrollment status in the Medicare Program, regulations found at 42 CFR 424.516 require that you submit updates and changes to your enrollment information in accordance with specified timeframes. Reportable changes include, but are not limited to changes in: (1) legal business name (LBN)/tax identification number (TIN), (2) practice location, (3) ownership, (4) authorized/delegated officials, (5) changes in payment information such as changes in electronic funds transfer information, and (6) final adverse legal actions, including felony convictions, license suspensions or revocations of a health care license, an exclusion or debarment from participation in Federal or State health care program, or a Medicare revocation by a different Medicare contractor.

Providers and suppliers may enroll or make changes to their existing enrollment in the Medicare program using the Internet-based Provider Enrollment, Chain and Organization System (PECOS). To apply via the Internet-based PECOS or to download the CM-855 enrollment applications, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll.

If additional changes are necessary or if you have any questions, feel free to contact our Provider Contact Center at 866-830-3925.

Sincerely,

Nakia Y. Mack
Provider Enrollment Analyst

(156)

12220000011

State of Tennessee
Department of Finance and Administration
Bureau of TennCare
310 Great Circle Road
Nashville, Tennessee 37202-1700

August 9, 2012

CAREALL HOME CARE SERVICES/9020
ATTN: ADMINISTRATOR
901 HIGHWAY 51 SOUTH
COVINGTON, TN 38019

NPI Number: 1194780569
Provider Number: 0447503

Dear Provider:

We have received and processed your revalidation Medicaid enrollment application packet. Please note that if you need to make any future changes to the information contained in the application you need to mail or visit our website at http://www.tn.gov/tenncare/pro-forms2.html. All changes must be reported within 30 days.

Please submit completed application(s) to:

Bureau of TennCare
310 Great Circle Road
Nashville, TN 37202
Attn: Provider Enrollment Unit

If you have questions regarding this letter please contact the Provider Enrollment line between the hours of 8:00 to 4:00 Monday through Friday at 1-800-852-2683, for additional enrollment applications visit our website at http://www.tn.gov/tenncare/pro-forms2.html.

Sincerely,

Provider Enrollment Unit

12220000001

State of Tennessee
Department of Finance and Administration
Bureau of TennCare
310 Great Circle Road
Nashville, Tennessee 37202-1700

August 9, 2012

PROFESSIONAL HOME HEALTH CARE/9104
326 WELCH ROAD
NASHVILLE, TN 37211

Provider Number:
0447503
NPI ID: 1194780569

Dear PROFESSIONAL HOME HEALTH CARE:

I would like to take this opportunity to welcome you to the Tennessee Medicaid/TennCare program. Your provider number is 0447503, your NPI ID is 1194780569 and the effective date of enrollment is May 19, 1986. Only claims with service dates on or after the effective date can be accepted for processing. NOTE: Tennessee Medicaid/TennCare will only pay you for the Medicare deductible and coinsurance for services rendered to Qualified Medicare Beneficiaries (QMB) and dual eligible Medicaid/QMB recipients.

If you have any questions regarding the submission of these claims to Medicaid, please contact our Provider Inquiry Unit at (615) 741-6669 or 1-800-852-2683.

All cross over claims must be submitted to the following address:

State of Tennessee
Department of Finance and Administration
P. O. Box 460
Nashville, TN 37202-0460

For proper identification and payment, all claims must be billed with the complete provider name and number. Should the name or address, as shown above, change, please notify in writing the Provider Enrollment Department at the address below. In addition, any telephone or written correspondence with this office must include Tennessee Medicare/Medicaid provider number(s).

State of Tennessee
Department of Finance and Administration
310 Great Circle Road
Nashville, TN 37202-1700

12220000001

Provider Number: 0447503
NPI ID: 1194780569

The newly formed relationship between you and TennCare, as a provider, allows you to use the Automated Voice Response System (AVRS). The AVRS is accessed by calling 1-(800) 852-2683. During or after the greeting, select provider by pressing one (1) to advance to the AVRS main menu.

At the AVRS main menu, you may select to hear how to access information via our website, hear an explanation of special automated voice response system features or continue to the provider identification menu.

Once at the provider identification menu, you will need to identify yourself as a provider by selecting the appropriate selection, followed by the pound sign (#).

Next, you will be prompted to enter your Medicaid ID number followed by the pound sign (#). After entering your identification number, enter your four-digit AVRS PIN followed by the pound sign (#). Your AVRS PIN is 9999.

For information about using TennCare's Online Eligibility Verification, visit: http://www.tennesseeanytime.org/tncr/ simply complete the online registration agreement, print and forward via mail or fax.

The Bureau of TennCare requires providers to re-enroll every three years. During the re-enrollment process, the Bureau of TennCare will ask you to supply updated information and documentation required for continued participation.

If you have any questions regarding this letter, please call the Provider Enrollment line at 1-800-852-2683, between the hours of 8:00 to 4:00 Monday through Friday, or visit our website at http://www.tn.gov/tenncare/pro-forms2.html for additional information regarding the enrollment process.

Sincerely,

Annie J Cowan

Provider Services/Enrollment Unit

Attachment Section C, Contribution to the Orderly Development of Health Care

Item 7, d.

COPY

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
WEST TENNESSEE HEALTH CARE FACILITIES
29750 Highway 48 Bypass
JACKSON, TENNESSEE 38305

May 22, 2012

Ms. Melissa Carol Paris, Administrator
CareAll Home Care
901 Hwy. 51 South
Covington, Tennessee 38019

RE: Recertification Survey and Licensure Survey– 4/11/2012
Provider # 44-7503 - Licensure # 534288

Dear Ms. Paris:

On 5/21/12, our office completed a review of your plan of correction for the deficiencies cited, **recertification and licensure.** Based on the review, we are accepting your plan of correction for each and are assuming your facility is in compliance with all participation requirements.

If this office may be of any assistance to you, please do not hesitate to call (731) 984-9684.

Sincerely,

Kathy Zeigler

Kathy Zeigler, RN
Public Health Nurse Consultant 2

KZ/gk

(161)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	447503	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREALL	901 HWY 51 SOUTH COVINGTON, TN 38019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 173	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. This STANDARD is not met as evidenced by: Based on facility policy, medical record review and interview, it was determined the facility failed to ensure nursing staff notified the physician regarding development of new skin conditions, and initiated a change in the plan of care (POC) for 1 of 20 (Patient #14) sampled patients. The findings included: 1. Review of the facility's "Plan of Care - Verbal Orders - Recertifications" policy documented, "...Verbal Orders: The Physician shall be notified promptly of any changes in the patient's status, and the registered nurse or other appropriate professional will initiate a supplemental order for verbal orders received noting the problem/need, interventions to include skill...any specific instructions..." 2. Medical record review for Patient #14 documented a re-certification for a POC from 2/12/12 - 4/11/12. The 485/POC documented, "...SN [skilled nurse] Orders 2 WK 9 [2 times a week for 9 weeks]...SN to provide wound care each SN visit as follows... Left pointer finger, right knee, right big toe, right second toe--clean with soap and water, pat dry, apply 1% [percent] silver sulfadiazine cream, cover with 4 x [by] 4 and secure with tape..." Review of the nursing notes dated 2/15/12,	G 173	G 173 Patient #14 - Documented a re-certification for a POC (Plan of Care) from 02/12/12 - 04/11/12. The 485/POC documented: SN (Skilled Nurse): orders 2 WK 9 (2 times a week for 9 weeks) - SN to provide wound care each SN visits as follows..Left pointer finger, right knee, right big toe, right second to -- clean with soap and water, pat dry, apply 1% (percent) silver sulfadiazine cream, cover with 4 x (by) 4 and secure with tape. Supplementa orders have been writtn and the physician has been notified of the wound care changes and new orders 04/11/2012. The deficiency will be corrected by the Director of Patient Services ensuring that orders will be written for all new wound care and the MD notified of a change in the patient's condition. These measures or systemic changes will be put in place to ensure that the deficient practice will not recur: when a Skilled Nurse identifies a new or subsequent wound on a patient, the nurse will notify the physician and obtain an order for wound care. All Skilled Nurses will be in-serviced on the facilities "Plan of Care - Verbal Orders- Recertifications" Policy (#3.011 see attached) by 05/24/12. When a nurses identifies a change in wound, the physician will be notifed to obtain orders for wound care. The Director of Patient Services will monitor all new wound care orders weekly. The Director of Patient Services will ensure that	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa C. Parris RN | TITLE: Administrator | (X6) DATE: 4-27-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

(162)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	447503	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREALL	901 HWY 51 SOUTH COVINGTON, TN 38019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 173	Continued From page 1 2/18/12, 2/25/12, 3/1/12 and 3/3/12 documented wound care was performed to the patient's left big toe and the right fifth toe. The treatment for these two areas were not addressed in the POC. A nurse note dated 2/21/12 documented a new area on the top of the right foot on the left and the right side of the patient's foot. These new areas were treated by the nurse. There were no supplemental orders documented and no communication with the physician regarding the newly identified areas. 4. During a telephone interview on 4/11/12 at 10:30 AM, the Director of the branch office for Patient #14 stated, "...the fifth right toe and the left big toe should be on the 485...that will be on the new 485..." When asked what she expected of nursing when the new area on the top of the foot was identified on 2/21/12. The Director stated, "Supplemental order...Is there not one?..." The Director verified there were areas being treated with no physician's order and the lack of documentation the physician was notified of changes in the patient's status.	G 173	G 173 continued: orders have been written and the Plan of Care/Recertificatoin is updated per policy (see attached policy #03.011). Each Director of Patient Services will be in-serviced on attached policy #03.011 and the policy will be reviewed annually by all Skilled Nurses. The corrected action will be monitored to ensure that all the deficient practice does not recur as follows: The Director of Patient Services will review all Recertifications/Verbal Orders every 60 days for accurancy and will update the 485/Plan of Care as needed. All Patient records will be reviewed by the Director of Patient Services prior to billing for complete accurate orders. All records will be reviewed by the Director of Patient Services Patient Care Coordinator every 60 days for complete and accurate orders at recertification. The Performance Improvement Coordinator will review at least 10 % (percent) of all records for deficiency in lack of wound care orders. If deficiencies, the subsequent with additional education to appropriate staff will be provided. All Nursing Staff will be in-serviced on policy # 03.011 (see attached) by 05/24/2012.	
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on review of facility policy, medical record review, observation and interview, it was determined the facility failed to ensure all	G 337	G 337 The deficiency will be corrected as follows: Patient #1, the MD was notified by the Skilled Nurse that the caregiver is cutting the Metoprolol ER in half every day and the medication profile in the patient's record was updated with correct medications 04/09/2012.	

(163)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	447503	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREALL	901 HWY 51 SOUTH COVINGTON, TN 38019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 337	Continued From page 2 medications patients were taking were identified accurately in the medical record for 3 of 10 (Patient #1, 3 and 7) sampled patients with home visits. The findings included: 1. Review of the facility's "Medication Review" policy documented, "...The purpose of this policy is to establish guidance for medication review...Procedure...The drug profile is updated as medications are discontinued, added or changed, or at least every 60 days..." 2. The following medication discrepancies were noted during the home visit conducted on 4/9/12 at 2:15 PM for Patient #1: Metoprolol ER (extended release) 25 mg (milligram) was observed in the home but not on the Medication Profile. During an interview in the home on 4/9/12 at 3:00 PM, Patient #1's caregiver verified Metoprolol ER was given. Patient #1's caregiver stated, "...I cut that [Metoprolol ER] in half and give it every day..." During an interview in the driveway of Patient #1's home on 4/9/12 at 3:15 PM, Nurse #1 was asked when were the medications reconciled in the home. Nurse #1 stated, "...Every visit should do a medication reconcile, no, didn't check meds today [4/9/12]..." During an interview in the conference room on 4/11/12 at 9:10 AM, the Administrator was asked when should the medication profile be reconciled. The Administrator stated, "...Expect the	G 337	G 337 continued: Patient # 3, the MD was notified by the Skilled Nurse of the patient taking Fish Oil 1200 MG 1 a day and Centrum Silver 1 capsule a day and the medication profile was updated in the patient's record with these medications 04/10/2012/ Patient #7, the MD was notified by the Skilled Nurse of the patient taking 5 Filer Therapy tablets a day instead of Metamucil, the Flonase nasal spray, Claritin, Flora Q has been discontinued 04/13/2012, the medication profile was updated in the patient's record with these medications. These measures will be put in place to ensure that the deficient practice does not recur: The Skilled Nurse will be In-Serviced on polic # 03.006 Medication Review (see attached). The Skilled Nurse will be required to document on each skilled visit that medications were reviewed and the changes recorded on the visit note and on the medication profile in the patient's record 05/24/12. The corrective actions will be monitored to ensure that teh deficient practice does not recur as follows: The Director of Patient Services and or Patient Care Coordinator will review each record every 60 days to ensure that the medication profile has been updated in the patient record for any new, changed, or discontinued medications. The Performance Improvement Coordinator will review at least 10 % of patientrecords quarterly to ensure that the medications profile is accurate according to documented changes in the medications. A Quarterly onsite visit will be performed with a field RN to ensure that a medication review is being performed.	

(164)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	447503	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREALL	901 HWY 51 SOUTH COVINGTON, TN 38019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 337	Continued From page 3 medication profile to be updated when a medication is changed or added then reviewed every recertification as well..." 3. The following medication discrepancies were noted during the home visit conducted on 4/10/12 at 3:00 PM for Patient #3: Fish Oil 1200 mg, One A Day, Centrum Silver were observed in the home but not on the Medication Profile. During an interview in the home on 4/10/12 at 3:00 PM, Patient #3 confirmed taking Fish Oil 1200 mg one daily, One A Day one daily, Centrum Silver one daily. During an interview in the home on 4/10/12 at 3:00 PM, Nurse #2 confirmed Fish Oil, One A Day and Centrum Silver were not on the medication profile. During an interview in the conference room on 4/10/12 at 3:45 PM, the Director of Patient Services confirmed the medication profile for Patient #3 was not updated. 4. Medical record review for Patient #7 documented the following medications on the Medication Profile: Flora Q one tablet twice a day, Metamucil 2 scoops once a day, Flonase nasal spray two spays in each nostril once a day and Claritin 10 mg one tablet once a day. Observation and review of the medications with Patient #7, during a home visit, on 4/10/12 at 10:18 AM, revealed the patient did not have Flora Q , Metamucil powder, Flonase nasal spray or Claritin tablets in her plastic medication container.	G 337	G 337 Continued All Skilled Nurses will be in-serviced on the medication review policy (#03.006) on hire and annually.	

(165)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	447503	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREALL	901 HWY 51 SOUTH COVINGTON, TN 38019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 337	Continued From page 4 During an interview on 4/10/12 at 10:20 AM, Patient #7 stated, "...taking 5 fiber therapy tablet a day (observed in the medication box) instead of the Metamucil...I'm out of Flonase nasal spray, haven't used it in awhile...no I don't take Claritin...No I don't know what Flora Q is..." During an interview on 4/10/12 at 10:20 AM, the medical social worker from the agency verified the medications were on the agency list but were not found in the patient's home.	G 337		

(166)

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNH159	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREALL	901 HWY 51 SOUTH COVINGTON, TN 38019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 510	1200-8-26-.05 (10) Admissions, Discharge and Transfers (10) A discharge plan and summary shall be completed on each patient. This Rule is not met as evidenced by: Based on medical record review and interview, it was determined the agency failed to complete a discharge summary for 2 of 3 (Patient #18 and 19) sampled discharged patients. The findings included: 1. Medical record review for Patient #18 documented the start of care date was 6/24/11 with diagnoses of Urinary Tract Infection and Obstructive Chronic Bronchitis. Review of a physician's order dated 2/16/12 documented, "...d/c [discharge] from home health services effective 2/16/12 per pt [patient] request..." Medical record review revealed a discharge date of 2/16/12. No discharge summary was completed. 2. Medical record review for Patient #19 documented the start of care date was 1/10/12 with diagnoses of Acute Onset Chronic Heart Failure and Chronic Kidney Disease. Review of a transfer form dated 1/31/12 documented the patient had transferred to a nursing home on 1/30/12. The last home health visit was documented as 1/30/12. There was no documentation the home health agency conducted visits or called the patient from 1/30/12 - 3/19/12. Medical record review revealed a discharge date of 3/19/12. No discharge summary was completed.	H 510	H-510 The deficiency will be corrected by a discharge summary being completed on patient #18 and #19 and sent to the attending physician for signature. The nursing staff and or Director of Patient Services will complete a discharge summary on all patients discharged for the agency, according to policy # 03.007 (see attached discharge summaries) Date: 05-24-2012 These measures will be put in place to ensure that the deficient practice does not recur: All nursing staff will be in serviced on the policy and procedure for completing a discharge summary, sending to the physician for signature, returned and placed in the medical record. (see attached policy 03.007) This education will also be provided to all nursing staff on hire. The Director of Patient Services will review all patients to be discharged from the agency for appropriateness and that the discharge summary has been completed and sent to the physician for signature. Date: 05-24-2012 This corrective action will be monitored to ensure that the deficient practice does not recur by: All discharge records will be reviewed by the Director of Patient Services at the time of discharge to ensure that the patient has been appropriately discharged, that the physician has been consulted, that a discharge summary has been written and sent to the physician for signature, and that it is returned to the agency and incorporated in the patient's medical record per Policy # 03.007. The Performance Improvement Director will review 10% of the agency records quarterly, one half of which will be discharge	

Division of Health Care Facilities

Melissa C. Parish RN, Administrator — TITLE — (X6) DATE 4-27-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(167)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNH159	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREALL	901 HWY 51 SOUTH COVINGTON, TN 38019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 510	Continued From page 1 During an interview in the conference room on 4/11/12 at 11:45 AM, the Director of Clinical Regulatory Regional Operations confirmed there was no documentation of a discharge summary for Patient #18 and 19.	H 510	H-510 Continued: charts. The discharged charts will be reviewed for appropriateness of discharge and if the discharge summary has been completed and sent to the physician for signature. The record will also be checked to make sure the discharge summary has been returned by the physician and incorporated in the medical record. If deficiencies are found with these audits then further education on policy #03.006 will be provided to the nursing staff and corrections made to the record. Date: 05-24-2012	

(168)

Back to Top

Policy Description:	Number:
MEDICATION REVIEW	**03.006**

PURPOSE:

The purpose of this policy is to establish guidance for medication review.

MEDICATION REVIEW:

The comprehensive patient assessment performed by Agency professionals will include a review of the patient's drug regimen in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects and drug interactions, duplicate drug therapy and noncompliance with drug therapy.

- Professionals will monitor the medications of each patient for medication effectiveness and actual or potential medication-related problems.
- Professionals will check all medications to identify possible ineffective drug therapy or adverse reactions and significant side effects or drug interactions.
- Professionals will notify the physician promptly of any problems noted.
- Professionals will collaborate with the physician and pharmacist as appropriate for medication monitoring.
- Professionals will use the results of ongoing medication monitoring to evaluate the patient's compliance with prescribed therapy and to identify any complications or problems related to the therapy.
- Professionals will communicate the findings of patient medication monitoring to other appropriate professionals involved in the patient's care.
- Professionals will maintain a current medication profile of the patient's current medication therapy.
- The professional will obtain a medication and drug use history upon admission, as applicable and available.
- All known over-the-counter medications taken on a PRN basis and all routine medications will be listed on the drug profile and/or on physician's order at the time of the patient's admission to the Agency in order to identify drug interactions and side effects.
- Patients who are only receiving therapy services will have a drug profile that will include the medications being taken at the time of the admission, the dosage, frequency and route of administration. The therapist will review all medications to ascertain the need for a more in-depth review by the nurse. The medications will be listed on the plan of care. The medications will be updated at least once every 60 days. This policy for therapy monitoring and review also applies when nursing begins treating the patient, but discharges the patient before therapy goals are completed.
- A notation may be made on the skilled nursing visit note, as well. If the patient is recertified, all new and changed medications will be included in the updated plan of care.
- The nurse will instruct the patient on appropriate medication reactions and side effects. Instructions will also be included for appropriate modifications in diet. For medications such as inhalation treatments, infusion therapy and insulin mixing, the nurse will instruct the patient in

proper conditions for preparing such medications. The nurse will also instruct the patient regarding medications that require special conditions for storage to ensure stability, such as storing nitroglycerin in a brown bottle and out of the heat.

PROCEDURE:

1. When the patient is admitted to the Agency, the professional takes a medication history and obtains an accurate list of all prescribed and over-the-counter medications being taken regularly and on a PRN basis by the patient. All medications are listed on the drug profile. The original drug profile is maintained in the Medical Record. The drug profile is updated as medications are discontinued, added or changed, or at least once every 60 days.
2. When verbal medication orders are given to a licensed nurse or therapist, a supplemental order will be written and sent to the physician for verification/signature. All other medication changes noted in the home, whether over-the-counter or prescription will be verified by the physician and/or documented in the medical record.
3. The professional reviews all medications being taken for ineffectiveness, adverse reactions, significant side effects, drug allergies and inaccurate or incorrect instructions or dosages. Any problems are reported to the physician. Any inaccuracies are clarified with the physician and/or pharmacist.
4. The professional notes the classification of each medication on the drug profile. If a medication is unknown and not listed in the current *Physicians' Desk Reference* (PDR) or other authoritative drug reference, the professional may call the pharmacist for written literature on the medication.
5. The professional monitors the patient for medication effectiveness, compliance with regimen and any complications or problems related to the therapy. Any discrepancies or problems are documented in the visit note. Problems are communicated to the physicians and/or pharmacists.
6. As appropriate, the professional notifies other professionals involved in the patient's care of any problems or findings related to medication monitoring.

Policy Description:	Number:
DISCHARGE AND TRANSFER	**03.007**

PURPOSE:

The purpose of this policy is to establish the Agency's guidelines on discharge and transfer.

DISCHARGE:

Reasons for termination of service by the Agency include the following:

- The treatment objectives are attained or are not attainable.
- The patient no longer requires skilled care and/or services.
- The patient's therapy has been completed but patient continues to require health care through another agency/facility.
- The range of patient needs cannot be met by the patient or family, even with part-time intermittent care from Agency personnel.
- The patient's life situation is not conducive to providing for his maintenance and supervision.
- Services can no longer be provided safely and/or effectively in the patient's place of residence.
- A change in the patient's condition requires care or services other than those provided by the Agency.
- Another person (i.e., family member) is available to provide the required service.
- The patient and/or his family refuse to cooperate in attaining treatment objectives.
- The patient refuses to follow the physician's prescribed plan of treatment.
- The patient and/or his family fail to provide a safe working environment.
- There is no one available in the home to give necessary care to the patient between visits from Agency personnel.
- The patient moves from the geographic area served by the Agency.
- The physician fails to renew his orders as required by law or the patient changes his physician and orders cannot be obtained from the new physician.
- The physician gives orders which are not consistent with the stated diagnosis, as required by law, and fails upon Agency request to give the needed orders.
- The Agency is closing out a particular service or all of its services.
- The patient expires.
- The patient, family or physician requests discharge/transfer.
- The patient is transferred to an ICF, nursing home or another health care agency/facility.
- The patient is in an inpatient facility at time of recertification.
- The intermediary or MCO (managed care organization) notifies the Agency, that the services provided no longer qualifies for coverage.
- The patient's source of payment has changed i.e., Medicare to Medicaid, etc.

Back to Top

Policy Description:	Number:
DISCHARGE AND TRANSFER	**03.007**

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

CONSENT CALENDAR

January 2, 2014

Mary Ellen Foley, Project Director
CareAll Management, LLC
326 Welch Road
Nashville, TN 37211

RE: Certificate of Need Application for Professional Home Health Care, LLC d/b/a CareAll Homecare Home Care Services -- CN1312-049

Dear Ms. Foley:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need for the relocation of the home health agency's parent office from 901 Highway 51 South, Covington (Tipton County) to 1151 Tammbell Street, Brownsville (Haywood County). Service area is Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lauderdale, McNairy, Madison, Obion, Tipton, and Weakley Counties. The estimated project cost is $59,300.00.

Please be advised that your application is now considered to be complete by this office. Your application is being forwarded to the Tennessee Department of Health and/or its representative for review.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 30-day review cycle for **CONSENT CALENDAR** for this project will begin on January 1, 2014. The first thirty (30) days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the thirty (30)-day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review within the thirty (30)-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on February 26, 2014.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill /MAF

Melanie M. Hill
Executive Director

MMH:mab

cc: Trent Sansing, CON Director, Division of Health Statistics

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO: Trent Sansing, CON Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Cordell Hull Building, 6th Floor
425 Fifth Avenue North
Nashville, Tennessee 37247

FROM: Melanie M. Hill
Executive Director

DATE: January 2, 2014

RE: Certificate of Need Application
Professional Home Health Care, LLC d/b/a CareAll
Homecare Home Care Services -- CN1312-049
CONSENT CALENDAR

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a **CONSENT CALENDAR** thirty (30) day review period to begin on January 1, 2014 and end on February 1, 2014.

Should there be any questions regarding this application or the review cycle, please contact this office.

MMH:mab

Enclosure

cc: Mary Ellen Foley, Project Director

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor 502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

LETTER OF INTENT

The Publication of Intent is to be published in the Jackson Sun (Name of Newspaper) which is a newspaper of general circulation in Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lauderdale, McNairy, Madison, Obion, Tipton, and Weakley (County), Tennessee, on or before December 10, (Month/Day) , 2013 (Year), for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that: Professional Home Health Care, LLC D/B/A CareAll Homecare (Name of Applicant) Home Health Agency (Facility Type-Existing)

owned by: CareAll, LLC with an ownership type of a Limited Liability Company and to be managed by: CareAll Management, LLC intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]: Relocation of the home health agency parent(or principle) office from 901 Highway 51 South, Covington, Tipton county, Tennessee to the current location of its Brownsville branch office at 1151 Tammbell Street, Brownsville, Haywood county, Tennessee. Professional Home Health Care, LLC is licensed to serve Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lauderdale, McNairy, Madison, Obion, Tipton, and Weakley. Existing home care services will not be affected, and no service will be initiated or discontinued. The project does not impact patient care, involves no construction or capital expenditure or the acquisition or modification of any item of major medical equipment. Anticipated project cost is $ 59,300.

The anticipated date of filing the application is: December 13, 2013

The contact person for this project is Mary Ellen Foley (Contact Name) Project Director (Title) who may be reached at:

CareAll Management, LLC (Company Name) 326 Welch Road (Address)

(City) Nashville (State) Tennessee (Zip Code) 37211 615-331-6137 (Area Code / Phone Number)

Mary Ellen Foley (Signature) 12-09-2013 (Date)

mfoley@careallinc.com (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the agency.

State of Tennessee
Health Services and Development Agency
Andrew Jackson State Office Building, 9th Floor
502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

December 18, 2013

Mary Ellen Foley
Project Director
CareAll Management, LLC
326 Welch Road
Nashville, TN 37211

RE: Certificate of Need Application CN1312-049
Professional Home Health Care, LLC d/b/a CareAll Homecare Services

Dear Ms. Foley,

This will acknowledge our December 13, 2013 receipt of your application for a Certificate of Need for the relocation of the parent office of Professional Home Health Care, LLC d/b/a CareAll Homecare Services, an established home care organization (home health agency), from 901 Highway 51 South, Covington, (Tipton County), TN to the current location of its Brownsville branch office at 1151 Tammbell Street, Brownsville (Haywood County), TN.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 noon, Thursday, December 26, 2013. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

---

1. **Section A, Applicant Profile, Item 5**

   Your response is noted. The management agreement filed expired December 31, 2009. Please submit a current management agreement.

2. **Section A, Applicant Profile, Item 13**

   Are there any TennCare MCOs in the service of which the applicant does not contract? If yes, please identify the MCOs and explain why the applicant is not contracted.

Please complete the following chart for your service area counties

Total Home Health Patients Trends by County of Residence

County	*2010 JAR Total residents served	*2011 JAR Total residents served	*2012 JAR Total residents served	'10-'12 % change
Benton				
Carroll				
Chester				
Crockett				
Decatur				
Dyer				
Fayette				
Gibson				
Hardeman				
Hardin				
Haywood				
Henderson				
Henry				
Lauderdale				
McNairy				
Madison				
Obion				
Tipton				
Weakley				
TOTAL				

**Data available in Summary JAR Report-Report 6*

9. Section C, Need, Item 6. (Applicant's Historical and Projected Utilization)

Your response to this item is noted. Please complete the following charts:

County	2010 JAR Total patients served	2011 JAR Total patients served	2012 JAR Total patients served	2013 Total Projected Patients Served	2014 Total Projected Patients Served	2015 Total Projected Patients Served	2016 Total Projected Patients Served
Benton							
Carroll							
Chester							
Crockett							
Decatur							
Dyer							
Fayette							
Gibson							
Hardeman							
Hardin							
Haywood							
Henderson							
Henry							
Lauderdale							
McNairy							
Madison							
Obion							
Tipton							
Weakley							
TOTAL							

County	2010 JAR Total Visits	2011 JAR Total Visits	2012 JAR Total Visits	2013 Total Projected Visits	2014 Total Projected Visits	2015 Total Projected Visits	2016 Total Projected Visits
Benton							
Carroll							
Chester							
Crockett							
Decatur							
Dyer							
Fayette							
Gibson							
Hardeman							
Hardin							
Haywood							
Henderson							
Henry							
Lauderdale							
McNairy							
Madison							
Obion							
Tipton							
Weakley							
TOTAL							

It appears that the applicant is projecting an approximate 50% decline in visits between 2010 (85,421) and 2016 (42,236). Please discuss the reasons for this expected decline.

10. Section C. Economic Feasibility Item 4. (Historical Data Chart and Projected Data Chart)

The HSDA is utilizing more detailed Historical and Projected Data Charts. Please complete the revised information Historical and Projected Data Charts provided at the end of this request for supplemental information. Please note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should also include any management fees paid by agreement to third party entities not having common ownership with the applicant. Management fees should not include expense allocations for support services, e.g., finance, human resources, information technology, legal, managed care, planning marketing, quality assurance, etc. that have been consolidated/centralized for the subsidiaries of a parent company.

11. Section C. Economic Feasibility Item 5

Your response is noted. Using data from the Projected Data Chart please provide the projected average gross charge per patient/visit, projected deduction from revenue per patient/visit, and the projected net charge per patient/visit.

12. Section C. Economic Feasibility Item 10.

Please provide the most recent audited financial statements with accompanying notes, if available.

13. Section C, Contribution to Orderly Development, Item 3

It appears the applicant wages for Administrator, Director of Patient Services, and Office Coordinators are significantly less than the average annual wage in the service area. Does the applicant have difficulty recruiting for these three types of positions?

Is the applicant's salary for Field PT $166,675?

14. Proof of Publication

Please submit a copy of the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit which is supplied by the newspaper as proof of the publication of the letter of intent.

15. Project Completion Forecast Chart (PCFC)

This application will not be heard by the Agency any sooner than February 26, 2014. Please put this date in the "Initial Decision date" line and please show on line 11 of the resubmitted revised PCFC when the applicant plans to finalize the relocation of the home health agency's parent office and on line 13 when the Final Project Report Form is intended to be filed with the HSDA.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is February 14, 2014. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ɔ 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please contact this office.

Sincerely,

Mark A. Farber
Deputy Director

Enc.

ISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in _____ (Month).

		Year____	Year___	*Year*____
A.	Utilization Data (Specify unit of measure)	_____	_____	_____
B.	Revenue from Services to Patients			
	1. Inpatient Services	$_____	$_____	$_____
	2. Outpatient Services	_____	_____	_____
	3. Emergency Services	_____	_____	_____
	4. Other Operating Revenue (Specify)_____	_____	_____	_____
	Gross Operating Revenue	$_____	$_____	$_____
C.	Deductions from Gross Operating Revenue			
	1. Contractual Adjustments	$_____	$_____	$_____
	2. Provision for Charity Care	_____	_____	_____
	3. Provisions for Bad Debt	_____	_____	_____
	Total Deductions	$_____	$_____	$_____
NET OPERATING REVENUE		$_____	$_____	$_____
D.	Operating Expenses			
	1. Salaries and Wages	$_____	$_____	$_____
	2. Physician's Salaries and Wages	_____	_____	_____
	3. Supplies	_____	_____	_____
	4. Taxes	_____	_____	_____
	5. Depreciation	_____	_____	_____
	6. Rent	_____	_____	_____
	7. Interest, other than Capital	_____	_____	_____
	8. Management Fees:			
	a. Fees to Affiliates	_____	_____	_____
	b. Fees to Non-Affiliates	_____	_____	_____
	9. Other Expenses – Specify on separate page 14	_____	_____	_____
	Total Operating Expenses	$_____	$_____	$_____
E.	Other Revenue (Expenses) – Net (Specify)_____	$_____	$_____	$_____
NET OPERATING INCOME (LOSS)		$_____	$_____	$_____
F.	Capital Expenditures			
	1. Retirement of Principal	$_____	$_____	$_____
	2. Interest	_____	_____	_____
	Total Capital Expenditures	$_____	$_____	$_____
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		$_____	$_____	$_____

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in _____ (Month).

		Year_____	Year_____
A.	Utilization Data (Specify unit of measure)	_____	_____
B.	Revenue from Services to Patients		
	1. Inpatient Services	$_____	$_____
	2. Outpatient Services	_____	_____
	3. Emergency Services	_____	_____
	4. Other Operating Revenue (Specify)_____	_____	_____
	Gross Operating Revenue	$_____	$_____
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$_____	$_____
	2. Provision for Charity Care	_____	_____
	3. Provisions for Bad Debt	_____	_____
	Total Deductions	$_____	$_____
NET OPERATING REVENUE		$_____	$_____
D.	Operating Expenses		
	1. Salaries and Wages	$_____	$_____
	2. Physician's Salaries and Wages	_____	_____
	3. Supplies	_____	_____
	4. Taxes	_____	_____
	5. Depreciation	_____	_____
	6. Rent	_____	_____
	7. Interest, other than Capital	_____	_____
	8. Management Fees:		
	a. Fees to Affiliates	_____	_____
	b. Fees to Non-Affiliates	_____	_____
	9. Other Expenses – Specify on separate page 14	_____	_____
	Total Operating Expenses	$_____	$_____
E.	Other Revenue (Expenses) -- Net (Specify)_____	$_____	$_____
NET OPERATING INCOME (LOSS)		$_____	$_____
F.	Capital Expenditures		
	1. Retirement of Principal	$_____	$_____
	2. Interest	_____	_____
	Total Capital Expenditures	$_____	$_____

NET OPERATING INCOME (LOSS)
LESS CAPITAL EXPENDITURES $_____ $_____

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year____	Year___	*Year*____
1.	$_____	$_____	*$*_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
Total Other Expenses	$_____	$_____	*$*_____

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year____	Year___
1.	$_____	$_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
Total Other Expenses	$_____	$_____

COPY-
SUPPLEMENTAL-1

CareAll Homecare Services

CN1312-049

State of Tennessee
Health Services and Development Agency
Andrew Jackson State Office Building, 9th Floor
502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

SUPPLEMENTAL- # 1
December 27, 2013
9:45am

December 23, 2013

Mary Ellen Foley
Project Director
CareAll Management, LLC
326 Welch Road
Nashville, TN 37211

RE: Certificate of Need Application CN1312-049
Professional Home Health Care, LLC d/b/a CareAll Homecare Services

Dear Ms. Foley,

This will acknowledge our December 13, 2013 receipt of your application for a Certificate of Need for the relocation of the parent office of Professional Home Health Care, LLC d/b/a CareAll Homecare Services, an established home care organization (home health agency), from 901 Highway 51 South, Covington, (Tipton County), TN to the current location of its Brownsville branch office at 1151 Tammbell Street, Brownsville (Haywood County), TN.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 noon, Thursday, December 26, 2013. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

---

1. **Section A, Applicant Profile, Item 5**

   Your response is noted. The management agreement filed expired December 31, 2009. Please submit a current management agreement.

2. **Section A, Applicant Profile, Item 13**

   Are there any TennCare MCOs in the service of which the applicant does not contract? If yes, please identify the MCOs and explain why the applicant is not contracted.

3. **Section B, Project Description, Item IIA**

   Assuming the proposed project is approved, please discuss the location of the home office, the location of each branch office (city and county), and the counties that will be covered by each office.

4. **Section B, Project Description, Item IID**

   Please discuss each individual cost savings item and display how the cost savings total up to $245,544.

   Including the reduction in the wage index, what does the applicant estimate for annual decline in revenues?

   Does the applicant project an increase, decline, or status quo regarding patient volume? Please discuss.

5. **Section C, Need, Item 1.a. (Project Specific Criteria-Construction Renovation, Expansion, & Replacement of Health Care Institutions) (Items 2.a.and 2. b.)**

   Please provide responses to Criteria items 2.a.and 2. b on page 23 of the *Guidelines for Growth.*

6. **Section C, Need, Item 3 (Service Area)**

   Your response to this item is noted. Please submit a revised map that identifies all the counties in Tennessee and clearly identifies the service area counties.

7. **Section C, Need, Item 4. (Service Area Demographics)**

   Please complete the following chart.

Demographic Data	19 County Service Area Total	State of TN Total
Total 2014 Population		
Total 2018 Population		
2014-2018 Population % Change		
Age 65+ Pop. - 2014		
Age 65 Pop.+ - 2018		
Age 65+ Population % Change		
Age 65+ Population % of Total Population		
Median Household Income (Range)		
TennCare Enrollees		
TennCare Enrollees as % of Total Population		
Persons Below Poverty Level		
% of Total Population below Poverty Level		

8. **Section C, Need, Item 5 (Service Area Utilization)**

   Please complete the following Chart for home health agencies that serve one or more of your service area counties.

SUPPLEMENTAL- # 1
December 27, 2013
9:45am

Agency	Base County	# of Service Area Counties Served	2010 Patients	2011 Patients	2012 Patients	'10-'12 % change
Tennessee Quality Homecare – Northwest	Benton					
Baptist Memorial Home Care & Hospice	Carroll					
Elk Valley Health Services, Inc.	Davidson					
Home Care Solutions, Inc.	Davidson					
Tennessee Quality Homecare – Southwest	Decatur					
Volunteer Homecare of West Tennessee	Decatur					
Regional Home Care – Dyersburg	Dyer					
NHC Homecare	Fayette					
Where the Heart Is	Fayette					
NHC Homecare	Gibson					
Volunteer Home Care, Inc.	Gibson					
Amedisys Home Health	Hamilton					
Deaconess Homecare II	Hardin					
Hardin Medical Center Home Health	Hardin					
Regional Home Care – Lexington	Henderson					
Henry Co. Medical Center Home Health	Henry					
St. Thomas Home Health (fka Hickman Community Home Care, Inc.)	Hickman					
Amedisys Home Health Care	Madison					
Extendicare Home Health of West Tennessee	Madison					
Intrepid USA Healthcare Services	Madison					
Medical Center Home Health	Madison					
Regional Home Care – Jackson	Madison					
Careall Homecare Services	Maury					
NHC Homecare	Maury					

Extendicare Home Health of Western Tennessee	Obion					
Magnolia Regional Health Care Home Hospice	Other (Corinth, MS)					
Regional Home Care Parkway	Other (Fulton, KY)					
Accredo Health Group, Inc.	Shelby					
Alere Women's and Children's Health, LLC	Shelby					
Amedisys Home Care (fka Tender Loving Care)	Shelby					
Amedisys Home Health Care	Shelby					
Amedisys Tennessee, LLC	Shelby					
Americare Home Health Agency, Inc.	Shelby					
Baptist Trinity Home Care	Shelby					
Baptist Trinity Home Care – Private Duty	Shelby					
Best Nurses, Inc.	Shelby					
Extended Health Care, Inc. (fka Elder Care, Inc.)	Shelby					
Family Home Health Agency	Shelby					
Functional Independence Home Care, Inc.	Shelby					
Home Health Care of West Tennessee, Inc.	Shelby					
Homechoice Health Services	Shelby					
Interim Healthcare of Memphis, Inc.	Shelby					
Intrepid USA Healthcare Services	Shelby					
Maxim Healthcare Services, Inc.	Shelby					
Methodist Alliance Home Care	Shelby					
No Place Like Home, Inc.	Shelby					
Willowbrook Visiting Nurse Association	Shelby					
Baptist Home Care & Hospice – Covington	Tipton					
Careall Homecare Services	Tipton					
Careall Homecare Services	Weakley					

Please complete the following chart for your service area counties

Total Home Health Patients Trends by County of Residence

County	*2010 JAR Total residents served	*2011 JAR Total residents served	*2012 JAR Total residents served	'10-'12 % change
Benton				
Carroll				
Chester				
Crockett				
Decatur				
Dyer				
Fayette				
Gibson				
Hardeman				
Hardin				
Haywood				
Henderson				
Henry				
Lauderdale				
McNairy				
Madison				
Obion				
Tipton				
Weakley				
TOTAL				

**Data available in Summary JAR Report-Report 6*

9. Section C, Need, Item 6. (Applicant's Historical and Projected Utilization)

Your response to this item is noted. Please complete the following charts:

SUPPLEMENTAL- # 1
December 27, 2013
9:45am

County	2010 JAR Total patients served	2011 JAR Total patients served	2012 JAR Total patients served	2013 Total Projected Patients Served	2014 Total Projected Patients Served	2015 Total Projected Patients Served	2016 Total Projected Patients Served
Benton							
Carroll							
Chester							
Crockett							
Decatur							
Dyer							
Fayette							
Gibson							
Hardeman							
Hardin							
Haywood							
Henderson							
Henry							
Lauderdale							
McNairy							
Madison							
Obion							
Tipton							
Weakley							
TOTAL							

County	2010 JAR Total Visits	2011 JAR Total Visits	2012 JAR Total Visits	2013 Total Projected Visits	2014 Total Projected Visits	2015 Total Projected Visits	2016 Total Projected Visits
Benton							
Carroll							
Chester							
Crockett							
Decatur							
Dyer							
Fayette							
Gibson							
Hardeman							
Hardin							
Haywood							
Henderson							
Henry							
Lauderdale							
McNairy							
Madison							
Obion							
Tipton							
Weakley							
TOTAL							

It appears that the applicant is projecting an approximate 50% decline in visits between 2010 (85,421) and 2016 (42,236). Please discuss the reasons for this expected decline.

10. Section C. Economic Feasibility Item 4. (Historical Data Chart and Projected Data Chart)

The HSDA is utilizing more detailed Historical and Projected Data Charts. Please complete the revised information Historical and Projected Data Charts provided at the end of this request for supplemental information. Please note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should also include any management fees paid by agreement to third party entities not having common ownership with the applicant. Management fees should not include expense allocations for support services, e.g., finance, human resources, information technology, legal, managed care, planning marketing, quality assurance, etc. that have been consolidated/centralized for the subsidiaries of a parent company.

11. Section C. Economic Feasibility Item 5

Your response is noted. Using data from the Projected Data Chart please provide the projected average gross charge per patient/visit, projected deduction from revenue per patient/visit, and the projected net charge per patient/visit.

12. Section C. Economic Feasibility Item 10.

Please provide the most recent audited financial statements with accompanying notes, if available.

13. Section C, Contribution to Orderly Development, Item 3

It appears the applicant wages for Administrator, Director of Patient Services, and Office Coordinators are significantly less than the average annual wage in the service area. Does the applicant have difficulty recruiting for these three types of positions?

Is the applicant's salary for Field PT $166,675?

14. Proof of Publication

Please submit a copy of the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit which is supplied by the newspaper as proof of the publication of the letter of intent.

15. Project Completion Forecast Chart (PCFC)

This application will not be heard by the Agency any sooner than February 26, 2014. Please put this date in the "Initial Decision date" line and please show on line 11 of the resubmitted revised PCFC when the applicant plans to finalize the relocation of the home health agency's parent office and on line 13 when the Final Project Report Form is intended to be filed with the HSDA.

SUPPLEMENTAL- # 1
December 27, 2013
9:45am

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is February 14, 2014. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

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Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ɔ 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please contact this office.

Sincerely,

Mark A. Farber
Deputy Director

Enc.

SUPPLEMENTAL- # 1
December 27, 2013
9:45am

ISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in _____ (Month).

	Year____	Year___	*Year*____
A. Utilization Data (Specify unit of measure)	_____	_____	_____
B. Revenue from Services to Patients			
1. Inpatient Services	$_____	$_____	$_____
2. Outpatient Services	_____	_____	_____
3. Emergency Services	_____	_____	_____
4. Other Operating Revenue (Specify)_____	_____	_____	_____
Gross Operating Revenue	$_____	$_____	$_____
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	$_____	$_____	$_____
2. Provision for Charity Care	_____	_____	_____
3. Provisions for Bad Debt	_____	_____	_____
Total Deductions	$_____	$_____	$_____
NET OPERATING REVENUE	$_____	$_____	$_____
D. Operating Expenses			
1. Salaries and Wages	$_____	$_____	$_____
2. Physician's Salaries and Wages	_____	_____	_____
3. Supplies	_____	_____	_____
4. Taxes	_____	_____	_____
5. Depreciation	_____	_____	_____
6. Rent	_____	_____	_____
7. Interest, other than Capital	_____	_____	_____
8. Management Fees:			
a. Fees to Affiliates	_____	_____	_____
b. Fees to Non-Affiliates	_____	_____	_____
9. Other Expenses – Specify on separate page 14	_____	_____	_____
Total Operating Expenses	$_____	$_____	$_____
E. Other Revenue (Expenses) – Net (Specify)_____	$_____	$_____	$_____
NET OPERATING INCOME (LOSS)	$_____	$_____	$_____
F. Capital Expenditures			
1. Retirement of Principal	$_____	$_____	$_____
2. Interest	_____	_____	_____
Total Capital Expenditures	$_____	$_____	$_____
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$_____	$_____	$_____

SUPPLEMENTAL- # 1
December 27, 2013
9:45am

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in _____ (Month).

		Year_____	Year_____
A.	Utilization Data (Specify unit of measure)	_____	_____
B.	Revenue from Services to Patients		
	1. Inpatient Services	$_____	$_____
	2. Outpatient Services	_____	_____
	3. Emergency Services	_____	_____
	4. Other Operating Revenue (Specify)_____	_____	_____
	Gross Operating Revenue	**$**_____	**$**_____
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$_____	$_____
	2. Provision for Charity Care	_____	_____
	3. Provisions for Bad Debt	_____	_____
	Total Deductions	**$**_____	**$**_____
NET OPERATING REVENUE		**$**_____	**$**_____
D.	Operating Expenses		
	1. Salaries and Wages	$_____	$_____
	2. Physician's Salaries and Wages	_____	_____
	3. Supplies	_____	_____
	4. Taxes	_____	_____
	5. Depreciation	_____	_____
	6. Rent	_____	_____
	7. Interest, other than Capital	_____	_____
	8. Management Fees:		
	a. Fees to Affiliates	_____	_____
	b. Fees to Non-Affiliates	_____	_____
	9. Other Expenses – Specify on separate page 14	_____	_____
	Total Operating Expenses	**$**_____	**$**_____
E.	Other Revenue (Expenses) -- Net (Specify)_____	$_____	$_____
NET OPERATING INCOME (LOSS)		**$**_____	**$**_____
F.	Capital Expenditures		
	1. Retirement of Principal	$_____	$_____
	2. Interest	_____	_____
	Total Capital Expenditures	**$**_____	**$**_____

NET OPERATING INCOME (LOSS) $_____ $_____
LESS CAPITAL EXPENDITURES

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year____	Year___	*Year*____
1.	$_____	$_____	*$*_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
Total Other Expenses	$_____	$_____	*$*_____

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year____	Year___
1.	$_____	$_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
Total Other Expenses	$_____	$_____

Certificate of Need Application

Professional Home Health Care, LLC D/B/A

CareAll Homecare Services

Additional information

December 23, 2013

SUPPLEMENTAL- # 1
December 27, 2013
9:45am

Responses to the December 19, 2013 supplemental information request.

1. *Section A, Applicant Profile, Item 5*
   Your response is noted. The management agreement filed expired December 31, 2009. Please submit a current management agreement.
   Response: *See attached current management agreement.*

2. *Section A, Applicant Profile, Item 13*
   Are there any TennCare MCO's in the service of which the applicant does not contract? If yes, please identify the MCOs and explain why the applicant is not contracted.
   Response: We have no contract at this time with United Health Care (Americhoice). We provided services through a provider contract with United Health Care until December 31, 2009 when the MCO terminated our contract. The reason for termination was stated to be "limiting the provider network". We have attempted on two separate occasions since the termination to contract again with United Health Care. Each time our application was approved in credentialing but then refused at the corporate level. We intend to meet with the united Health Care representatives now that they have been awarded the TennCare contract again to negotiate a contract to provide these services.

3. *Section B, Project description, Item 2 A*
   Assuming the proposed project is approved, please discuss the location of the home office, the location of each branch office (city and county), and the counties that will be covered by each office.
   Response: The Brownsville home office location in Haywood County will directly provide home health services to Haywood County and the bordering areas of Hardeman, Madison, Fayette and Tipton counties. The Ripley branch office located in Lauderdale County will provide home health services to patients in Lauderdale and Tipton County as well as the bordering area of Dyer County. The Alamo branch office located in Crockett County will provide home health services to Crockett and Madison counties as well as the bordering areas of Gibson and Haywood County. The Henderson branch office located in Chester County will serve home health patients in Fayette, Hardeman, McNairy, Chester and Henderson counties as well as the bordering areas of Hardin and Decatur counties.

The branch office in Jackson located in Madison county serves Private Duty and Choices patients in Fayette, Hardeman, McNairy, Hardin, Decatur, Henderson, Chester, and Madison counties. The Private Duty division of the Brownsville office serves Private Duty and Choices patients in the counties of Haywood, Tipton, Lauderdale, Crockett and the bordering areas of Dyer and Gibson counties. Professional Home health Care, LLC currently has no patients at this time in the service areas of Carroll, Benton, Henry, Weakley, and Obion counties.

4. Section B, Project Description, Item 2 D

A. Please discuss each individual cost savings item and display how the cost savings total up to $245,544.

Response: The cost savings of $245,544 was derived from:
1. The elimination of the physical location in Covington providing an annual savings of $15,330 in plant operations. 2. The elimination of two staff positions in the Covington location including the Director of Patient Services and the Office Coordinator totaling a savings of $77,050 annually.
3. Annual administrative costs including management services, worker's compensation and insurance fees on the employee positions eliminated, phone service, and miscellaneous incidental cost to the operation of Covington totaling an annual savings of $168,494.

B. Including the reduction in the wage index, what does the applicant estimate for annual decline in revenues?

Response: We have provided revenue history and projections. Professional Home Health Care, LLC's business is approximately 60% Home Health and 40% Private Duty. The most significant portion of the Home Health business is Medicare and/or Medicare Advantage. Professional also serves multiple CBSA's in the West Tennessee area which of course, payment is based on where the beneficiary is served. The CMS final rule for home health agency payments for 2014 presents a net decrease in overall home health payments of 1.05%. Professional's decrease may be slightly higher as most Tennessee Urban CBSA's saw 3-5% decreases in Wage Index factors. As a vast majority of the service area is rural and the Wage Index value stayed level 2013 vs 2014, we are not projecting significant variances from CMS' net 1.05% as published. We do continue to feel the impact of the Government

Sequestration of 2%. The continued reduction in payment rates, which have occurred since 2010, the sequestration and other factors help explain the logic behind the request to move the parent office from Covington, Tipton County, to Brownsville, Haywood County.

C. *Does the applicant project an increase, decline, or status quo regarding patient volume?*

Response: Since July 2013 the applicant has experienced a significant decrease in patient volume. This has occurred as part of an overall restructure of operations. We anticipate servicing beneficiaries at current levels into the 2nd quarter of 2014. Expectations once the restructure is complete are to strategically progress toward expanding services in both the home health and private duty operations, to include all payer types, Medicare, Medicare Advantage, TennCare, private insurance and private pay.

5. *Section C, Need, Item 1.a (Project Specific Criteria-Construction Renovation, Expansion, & Replacement of Health Care Institutions) (Item 2.a. and 2.b.)*
Please provide responses to Criteria items 2.a. and 2.b. on page 23 of the "Guidelines for Growth".
2. for relocation or replacement of an existing licensed health care institution:

a. *The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.*

Response: The cost of the relocation was outlined in the Project Cost Chart including $2,500 for preparation and cost related to the filing of the CON application, $7,000 for the cost of moving furniture out of the Covington location and miscellaneous organizational cost of relocating the operations to other locations. The $46,800 is the annual cost of the new principle location in Brownsville, Haywood County. These cost total $56,300 and with the $3,000 filing fee total, brings the total project cost to $59,300. The strength of this project is the cost savings that the closing of the Covington location will provide, the improved access to the branch location and the agency's service area in relation to the new principle location, and the provision that the project provides closer access to a larger percentage of the Agency's patient population as

discussed in Section B, Project Description, Item 1. At this time no weaknesses of this alternative have been identified.

b. *The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.*
Response: With the CMS proposed 1.05% net reduction in reimbursement to home health in 2014, the annual cost reduction of closing the Covington location and the reorganization of Brownsville as the principle location demonstrates that there is an acceptable existing or projected future demand for the proposed project.

6. *Section C, Need, Item 3 (Service Area)*
Your response to this item is noted. Please submit a revised map that identifies all the counties in Tennessee and clearly identifies the service area counties.
Response: See attached map.

7. *Section C, Need item 4. (Service Area Demographics)*
Please complete the following chart.
Response: See attached chart.

8. Section C, Need, Item 5 (Service Area Utilization)
Please complete the following Chart for home health agencies that serve one or more of your service area counties.
Response: See attached charts.
Please complete the following chart for your service area counties.
Response: See attached chart.

9. *Section C, Need, Item 6.(Applicant's Historical and Projected Utilization)*
Your response to this item is noted. Please complete the following charts:
Response: See attached charts.
It appears that the applicant is projecting an approximate 50% decline in visits between 2010 (85,421) and 2016(42,236). Please discuss the reasons for this expected decline.
Response: As discussed earlier, since July 2013 the applicant has experienced a significant decrease in patient volume thus resulting in a significant decrease in visit volume. This has occurred as part of an overall

restructure of operations. We anticipate that the current levels of visits will continue into the 2nd quarter of 2014. Expectation once the restructure is complete are to strategically progress toward expanding services in both the home health and private duty operations, to include all payer types, Medicare, Medicare Advantage, TennCare, private insurance, and private pay.

10. *Section C. Economic feasibility item 4. (Historical Data Chart and Projected Data Chart)*
The HSDA is utilizing more detailed historical and projected Data charts. Please complete the revised information Historical and Projected Data Charts provided at the end of this request for supplemental information.
Response: See attached revised Charts.

11. *Section C. Economic Feasibility Item 5*
Your response is noted. Using data from the Projected Data Chart please provide the projected average gross charge per patient/visit, projected deduction from revenue per patient/visit, and the projected net charge per patient/visit.
Response: We bill at net rates, so we will not have gross charge per visit or deduction from revenue per visit. The projected average net charge per visit for 2015 and 2016 is $162 per visit. Note that projected net operating revenue for 2015 and 2016 on the projected data chart includes both home health and private duty net charges, and historically the mix has been 60% home health and 40 % private duty. The calculation of projected average net charge per visit is total net operating revenue at 60% divided by projected visits, or $162 per visit.

12. *Section C. Economic Feasibility Item 10*
Please provide the most recent audited financial statements with accompanying notes, if available.
Response: The financial statements are compiled internally, and are unaudited.

13. Section C, Contribution to Orderly Development, Item 3
It appears the applicant wages for Administrator, Director of Patient Services, and Office Coordinators are significantly less than the average

annual wage in the service area. Does the applicant have difficulty recruiting for these three types of positions?

Response: The Board of Directors along with management, as part of the company restructure since July 2013, have taken steps to address employee retention and recruiting. Wages for positions identified, Administrator, Director of Patient Services and Office Coordinator under revised structure are competitive in the local market. Recruiting in rural markets is challenging for most all positions, however the applicant has been successful in recruiting and hiring for these positions.

Is the applicant's salary for Field PT $166,675?

Response: The field therapist is paid on a per visit basis. Total earnings accordingly are based on productivity.

14. *Proof of Publication*

Please submit a copy of the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit which is supplied by the newspaper as proof of the publication of the letter of intent.

Response: See attached affidavit of Publication from the Jackson Sun.

15. *Project Completion Forecast Chart (PCFC)*

This application will not be heard by the Agency any sooner than February 26, 2014. Please put this date in the "initial Decision date" line and please show on line 11 of the resubmitted revised PCFC when the applicant plans to finalize the relocation of the home health agency's parent office and on line 13 when the Final Project Report Form is intended to be filed with the HSDA.

Response: Please see revised Project Completion Forecast Chart.

Attachment, Item 1- Section A, Applicant Profile, Item 5 Management Agreement

SERVICE AGREEMENT

THIS AGREEMENT is made and entered into as of the 1st day of October, 2009 by and among **CareAll, LLC ("CL"), CareAll Management, LLC ("CML")** and **James W. Carell ("Carell").**

WITNESSETH:

WHEREAS, CL is the owner of J. W. Carell Enterprises, LLC, Professional Home Health Care, LLC, University Home Health, LLC and VIP Nursing & Rehabilitation Service, LLC (the **"Agencies"**); and

WHEREAS, the Agencies are engaged in the home health care business; and

WHEREAS, CML is engaged in the business of providing management and services to health care agencies; and

WHEREAS, Carell is the president of CL and the Agencies and has a vast amount of experience in the home health care business; and

WHEREAS, CL considers it to be in its best interest to engage the services of CML and Carell; and

WHEREAS, CML and the Agencies entered into an Amended and Restated Service Agreement dated as of September 1, 2009 which shall be terminated as of the date of this Agreement; and

WHEREAS, CL, the Agencies, and Carell desire to terminate any and all other agreements by or among them and Carell pertaining to his compensation for services rendered and consulting fees or other methods of compensation and provide for his sole compensation as set forth herein.

NOW, THEREFORE, for and in consideration of these premises and other good and valuable considerations, the receipt and sufficiency of which is hereby acknowledged, the parties hereto agree as follows:

1. **Rights, Powers and Responsibilities.**

   a. CL hereby retains CML exclusively to provide the services specified herein for Agencies during the term of this Agreement.

   b. CL and CML agree that CL shall retain final authority with respect to all professional and ethical affairs of the Agencies, all fiscal affairs of Agencies, all general operating policies and all other aspects of the operation of Agencies, except as are specifically delegated to CML herein.

c. CML shall, with CL's approval, have the right to consent, in the name of Agencies through appropriate legal proceedings, the validity of application of any law, ordinance, ruling, regulation or requirement of any governmental agency having jurisdiction over Agencies. Agencies shall cooperate with CML with regard to the contest and Agencies shall pay any reasonable attorney's fees incurred with regard to such action. Counsel for the contest shall be selected by CML with approval.

d. CML shall have the obligation to process all third part claims for services rendered, including the right to contest adjustments and denials by third-party payers (or their agents), without requiring written consent of Agencies.

2. Services.

During the term of this Agreement, CML shall subject to Section 1 herein, provide the services set forth in Attachment A, Schedules 1 through 4, attached hereto and incorporated herein by reference.

3. Access to Records and Facilities.

Such books and records, as are maintained by CML for the purpose of providing services under this Agreement, shall be made available, upon request, to CL, its agents, accountants and attorneys, or upon receipt of a properly executed request, any representative of the Secretary of Health & Human Services of Comptroller General of the United States, during normal business hours. CML shall respond to any questions of CL concerning the books and records and shall assist Agencies' auditors in the conduct of an audit of Agencies' annual financial statements. CML agrees to retain said books and records for a period of four (4) years after the settlement date for each year's Medicare cost report.

4. Accreditation and License.

a. CML shall employ its best efforts to manage Agencies in such a manner as will ensure that all necessary licenses, permits, consents and approvals from all government agencies have jurisdiction over Agencies' operations are obtained and in compliance.

b. Neither CL, Agencies nor CML shall knowingly or purposefully take any action which shall:

(1) Cause any government authority having jurisdiction over the operation of Agency to institute any proceeding(s) for the rescission or revocation of any necessary license, permit, consent or approval, or

(2) Adversely affect Agencies' right to obtain and accept payments under Title XVIII of the Social Security Act, or any other public or private program for payment for medical services rendered.

5. Use of CML's Personnel and Services.

CML's staff specialists in such areas as accounting, auditing, budgeting, personnel, billing systems, clinical expertise, medical/utilization review, and third-party payments for home care services shall be actively utilized by Agencies in the day-to-day operation of Agencies when considered desirable by CML or upon the reasonable request of CL or Agencies.

6. Special Projects.

CML may, from time to time, engage consultants or teams of consultants, to perform projects in regard to services other than those stipulated in this Agreement, where such projects can be construed as contributing to improved operations of CL and Agencies, and their fees shall be paid by CL or Agencies. Such consultants may not be engaged, without approval of CL, in the event that their fees, charges and expenses in connection with the contemplated assignment could reasonably be expected to exceed One Thousand and No/100 ($1,000.00) Dollars.

7. CL's and Agencies' Representative.

CL and Agencies hereby appoint its president, or his or her designee, as its authorized representative to take any action necessary to enable CML to act on CL's or Agencies' behalf pursuant to this Agreement, including without limitation the authority to grant any necessary approvals or consents, and to receive any reports or other documents to be provided by CML under this Agreement.

8. Term.

The term of this Agreement shall be for a period of one (1) year commencing October 1, 2009 and ending September 30, 2010 and shall be automatically renewed on an annual basis for a term of one (1) year unless written notice of non-renewal is given by a party to the other parties at least sixty (60) days prior to the end of the initial term or a renewal term of this Agreement.

9. Event of Default – Termination by CML.

CML may terminate this Agreement if CL shall fail to keep, observe or perform any material covenant, agreement, term or provision of the Agreement to be kept, observed or performed by CL or Agencies and such default shall continue for a period of thirty (30) days after notice thereof by CML to CL.

10. Event of Default – Termination by CL.

a. Any of the following shall be an event of default hereunder on the part of CML:

(1) If CML shall fail to keep, observe, pay or perform any convenient obligation, agreement, term or provision of this Agreement to be kept, observed, paid or performed by CML and such default shall continue for a period of sixty (60) days after notice thereof by CL to CML.

(2) If any license necessary or desirable for the operation of Agencies is at anytime suspended, terminated or revoked, and such suspension, termination or revocation shall continue unstayed and in effect for a period of forty-five (45) days consecutively.

b. If the event of default shall be failure to make payment as provided in this Agreement, CL shall, in addition to recovery of the amount paid, be entitled to reasonable attorney's fees and costs of collection.

11. Management Fees.

a. During the term of this Agreement, CML and Carell shall be compensated for services rendered in accordance with fee schedules set forth in Attachment B, attached hereto and incorporated herein by reference.

b. CML shall invoice CL for services rendered by CML and Carell on or by the tenth (10^{th}) day of the month.

c. CL agrees to pay CML and Carell the monthly late fee in the amount equal to one and one-half percent (1½%) of any payment due CML or Carell which is not paid within ninety (90) days of the original invoice date.

d. The president of CL shall approve the payment of all management fees.

12. Non-assumption of Liabilities.

CML and Carell shall not, by entering into and performing this Agreement, become liable for any of the existing or future obligations, liabilities or debts of CL or Agencies, and will in its role as CML have only the obligations to exercise reasonable care in its management and handling of the funds generated from the operation of Agencies.

13. Notices.

All notices hereunder by either party to the other shall be in writing. All notices, demands and requests shall be deemed given when mailed, postage prepaid, registered or certified mail:

a. to CL at: 4015 Travis Drive, Suite 200
Nashville, TN 37211

b. to CML at: 326 Welch Road
Nashville, TN 37211

c. to Carell at: 6540 Radcliff Drive
Nashville, TN 37221

or to such other address, or to such other person who may be designated by notice given from time to time during the term of this agreement by one party to the other.

14. Assignability.

This Agreement may be assigned by either party and shall be binding upon its assigns and successors in interest.

15. Entire Agreement.

This Agreement contains the entire agreement between the parties hereto, and no representation or agreement, oral or otherwise, between the parties not embodied herein or attached hereto shall be of any force and effect. Any additions or amendments to this Agreement subsequent hereto shall be of no force and effect unless in writing and signed by the parties hereto.

16. Governing Law.

This Agreement has been executed and delivered in the State of Tennessee and all of the terms and provisions hereof and the rights and obligations of the parties hereto shall be construed and enforced in accordance with the laws thereof.

17. Captions and Headings.

The captions and headings throughout this Agreement are for convenience and reference only, and the words contained therein shall in no way be held or deemed to define, limit, describe, explain, modify, amplify or add to the interpretation, construction, or meaning of any provision of this or the scope or intent of this Agreement nor in any way affect the Agreement.

18. Impossibility of Performance.

CML shall not be deemed to be in violation of this Agreement if it is prevented, either directly or indirectly, from performing any of its obligations hereunder for any reason beyond its control, including without limitation, allowable Medicare funding, acts of God or the public enemy, flood or storm strikes, or statutory regulation or rule of any federal, state or local government, or any agency thereof.

19. Termination of Prior Agreements.

CareAll, Inc. and the parties hereto hereby terminate all prior service agreements and any other agreements pertaining to compensation to Carell as an officer of said parties or as a consultant.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year first above written.

"CL" CareAll, LLC

BY: _____
James W. Carell, Chief Manager/President

"CML" CareAll Management, LLC

BY: _____
J.W. Carell, Chief Manager/President

"Carell" _____
James W. Carell

CareAll, Inc. joins in this Agreement for the sole purpose of consenting to the provisions of Paragraph 19, above.

CareAll, Inc.

BY: _____
James W. Carell, President

ATTACHMENT "A"
TO SERVICE AGREEMENT
(October 1, 2009)

SERVICES TO BE PROVIDED BY CML

Schedule 1: Reimbursement Services

a. CML shall arrange for the preparation of Agencies' annual Medicare cost report.

b. CML shall continuously review and monitor the setting of payment rates, calculate where necessary and submit such computations to the fiscal intermediary as required. CML shall prepare, or cause to be prepared, the appropriate reports, if any, to be filed with the fiscal intermediary.

c. CML shall negotiate on behalf of Agencies, unless Agencies choose to conduct such negotiations, any repayment schedules necessary in the event Agencies are overpaid by third-party payers and lacks sufficient funds for immediate repayment.

d. CML shall regularly analyze Agencies' visit statistics and mix of visits in relation to the prospective pay system to ensure optimum use of staffing and financial resources.

e. CML shall conduct on behalf of Agencies, unless Agencies choose to conduct such negotiations, any formal and/or informal appellate proceedings in regard to reasonableness determinations made by the fiscal intermediary in regard to the Agencies' Medicare cost report. Said proceedings may be pursued to the Provider Reimbursement Review Board level. Beyond this level, appellate proceedings must have the approval of Agencies and this shall also mean that the expenses associated with proceedings after the Provider Reimbursement Review Board shall be borne by Agencies.

f. CML shall perform, on a periodic basis, special studies to ensure that Agencies are taking advantage of every available option, election and alternative with which to legitimately maximize the amount of reimbursement received from third-party payor in accordance with applicable law and regulation.

g. CML may conduct all dealings with local representatives of the fiscal intermediary, including, but not limited to, the following:

(1) Entrance and exist conferences;
(2) Repayment schedule;
(3) Administrative reviews;
(4) Appeal procedure up to the Provider Reimbursement Review Board stage; and
(5) Administrative Law Judge hearings.

h. CML shall handle all dealings on behalf of Agencies, unless Agencies choose to conduct such dealings, with representatives of respective government agencies concerned with the administration of Title XVIII of the Social Security Act.

i. CML shall advise Agencies on a regular basis of developments, legislative and otherwise, which may affect the operations of Agencies, e.g., certificate of need regulations, prospective reimbursement and National Health Insurance.

j. CML shall be responsible for collection and disbursement of all funds or monies, Medicare, Medicaid received by Agencies and maintain books and records in accordance with generally accepted accounting principles.

k. All funds received or generated by Agencies operations, shall be deposited by CML in a bank account(s) as designated by Agencies. Said accounts are defined as operating accounts, in the name of Agencies, out of which shall be disbursed all costs and expenses relative to the operation of Agencies. CML shall periodically review Agencies' working capital needs to ensure Agencies remain financially viable at all times. Any and all checks or documents of withdrawal from the operating accounts may be signed by CML.

Schedule 2: Clinical/Operational Consulting Services

a. CML shall prepare and deliver a quarterly status report of the affairs of Agencies with specific commentary on the number of visits, personnel status and current events and/or developments impacting Agencies' operations, within thirty (30) days of the preceding calendar quarter to which the status report relates.

b. CML shall prepare and deliver an annual report describing the operations, policies and problems with respect to Agencies covering in reasonable detail all aspects of Agencies. This report shall be delivered to Agencies within sixty (60) days of the preceding year or twelve (12) month period to which the report relates.

c. CML shall prepare and deliver such other reports as are reasonable, from time to time, requested by Agencies with regard to comparisons of Agencies to similar agencies and analysis of the relative efficiency of Agencies' various services.

d. CML shall interview for the position of Agencies' Administrator and make recommendation to Agencies' Owner based on interviewee's qualifications. All other positions in Agencies shall be hired by Agencies' Administrative or his or her designee.

e. CML shall periodically review the job related educational needs of Agencies' employees and shall schedule, organize and/or conduct such internal and/or external training programs and seminars as often as CML deems necessary, or at the request of Agencies for such training programs and seminars, to meet performance requirements for Agencies' employees.

j. CML shall establish and maintain an ongoing community relations program designed to assist the public with interpretation of Agencies' services and to foster good working relations with physicians and other providers within the health care community.

k. CML shall represent Agencies at meetings, conventions, seminars, and workshops related to the home health care field and/or specifically to Agencies, both on a local and national basis.

Schedule 3: Accounts Receivable/Billing/Purchasing/Computer Services

a. CML shall provide preparation, billing and collection of patient accounts. CML shall take all reasonable steps to ensure that all claims related to the production of revenue are processed on a timely basis, and in the format prescribed by servicing intermediaries. CML shall, institute on-line processing of claims, ADR's, etc., progressing to a totally paperless process.

b. CML shall enforce the rights of Agencies as a creditor under any contract or for the performance of any services, act as full power with the Agencies' intermediary for billing information, or correspondence to operate Agencies.

c. CML shall purchase, in accordance with approved purchasing policies, such medical supplies, solutions, equipment and vehicles (including leasing thereof), furniture, furnishings, materials and services (including service and maintenance contract) which are deemed necessary to the efficient operation of Agencies. Purchases, single or cumulative, in excess of Five Thousand and 00/100 ($5,000.00) Dollars will require approval of an officer or designee of Agencies.

d. CML shall take all responsible steps to assure orderly and prompt payment of bills, accounts payable, employee payroll taxes, general taxes levied on Agencies and insurance premiums of Agencies. CML's responsibility under this section shall be limited to the exercise of due care and reasonable diligence to apply funds collected in the operation of Agencies in a timely and prudent manner. CML does not assume the financial obligation for funding the payment of debts.

e. CML shall have the authority to arrange for lease equipment when it appears to be in the best interest of Agencies and Agencies shall have the final approval of such contracts.

Schedule 4: Accounting Services

a. CML shall maintain an adequate chart of account, accounting systems, internal controls and such other accounting and statistical data gathering systems as are necessary to comply with applicable law and regulations.

b. CML shall ensure that proper inventories of all of Agencies' fixed and current assets are maintained on a current basis and that adequate controls are exercised to maintain the security of Agencies' assets.

c. CML shall establish and maintain an internal cost containment program designed to stimulate employee interest in controlling cost wherever practicable and to promote employee awareness of the need to contain costs through proper procedure, work methods and adherence to Agencies' established policies.

d. CML shall prepare and process the bi-weekly Agencies payroll. Prepare and file all reports required by state and federal guidelines; quarterly state unemployment reports, 941's, 940's, W-2's, W-3's and 1099's.

e. CML shall prepare and deliver monthly financial statements containing a balance sheet and statement of income in conventional detail, within thirty (30) days after the end of the preceding calendar month to which the financial statement relates.

f. Not later than thirty (30) days prior to the commencement of each fiscal year, CML shall prepare and deliver to Agencies with respect to the following fiscal year:

(1) A capital expenditure budget outlining a program of capital expenditures for the next fiscal year. This budget shall designate proposed expenditures as either mandatory, desirable or optional;

(2) An operating budget setting forth an estimate of operating revenues and expenses for the next fiscal year. The budget shall be in conventional detail and shall contain narrative explanations of changes in utilization, rates, payroll and other factors differing significantly from the current year; and

(3) A projection of cash receipts and disbursements based upon the capital and operating budgets. This projection shall contain recommendations concerning the utilization of funds generated by excess cash flow or the need for temporary borrower where negative cash flow is anticipated.

ATTACHMENT "B"
TO SERVICE AGREEMENT
(October 1, 2009)

1. Management/Consulting Fees.

a. Compensation to CML

i. Home Health Care. Agency shall pay to CML six percent (6%) of its gross revenues generated from its home health are operations, payable monthly, on or before the fifteenth (15th) of each month based upon the preceding month's billings.

ii. Private Duty Care. Agency shall pay to CML fifteen percent (15%) of its gross revenues generated less direct labor costs from its private duty care operations, payable monthly, on or before the fifteenth (15th) of each month based upon the preceding month's billings.

b. Compensation to Carell (This represents total compensation to Carell as an officer of, and consultant to, CL, CML and the Agencies.)

i. Home Health Care. Agency shall pay to Carell twenty four percent (24%) of its gross revenues and five percent (5%) of its net profits before taxes generated from its home health care operations, payable monthly, on or before the fifteenth (15th) of each month based upon the preceding month's billings.

ii. Private Duty Care. Agency shall pay to Carell five percent (5%) of its gross revenues less direct labor costs and five percent (5%) of its net profits before taxes generated from its home health care operations, payable monthly, on or before the fifteenth (15th) of each month based upon the preceding month's billings.

2. OASIS (Outcomes and Assessment Information Sheet). CML shall develop and implement a program to assure the Oasis collection mandate is being achieved and Agencies shall pay CML for keying and processing OASIS set as follows:

Start of Care Set -	$50.00 per set
Follow Up Set -	$25.00 per set
Transfer Set -	$15.00 per set
Discharge Set -	$25.00 per set

3. Pre-Certification Fees.

   a. One Hundred Seventy Five and 00/100 Dollars ($175.00) per new pre-certification episode.

   b. Eighty Seven and 50/100 Dollars ($87.50) per carryover episode.

4. HHRG Nurse Consulting. Ninety and 00/100 Dollars ($90.00) per hour.

5. On Site Services. In the event that Agencies request that CML personnel perform services for Agencies on site, Agencies agree to pay CML the following discounted hourly rates:

Classification	Hourly Rate	
Chief Operating Officer/President	$ 150.00	
Chief Financial Officer	125.00	
Audit/Compliance Specialist	100.00	
Reimbursement Specialist	100.00	
Professional Support Specialist	100.00	
Administrative Assistant	53.30	
ADRs	249.50	per request
Pre-Certification	175.00	per request
Episodic Carryover	87.50	

Travel expense $0.55 per mile, in addition to lodging and food.

Note: If the total fees received by CML pursuant to Items 1-5, above, create a pre-tax profit for CML in excess of twenty percent (20%), CML shall pay to Carell an amount necessary to reduce CML's pre-tax profit to twenty percent (20%).

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FIRST AMENDMENT TO SERVICE AGREEMENT

THIS FIRST AMENDMENT TO SERVICE AGREEMENT ("First Amendment") is entered into as of the 1st day of May, 2011 by and among **CareAll, LLC** ("CL"), **CareAll Management, LLC** ("CML") and **James W. Carell** ("Carell").

W I T N E S S E T H:

WHEREAS, the parties hereto entered into a Service Agreement dated as of the 1st day of October, 2009 (the "**Service Agreement**"); and

WHEREAS, the parties wish to update Attachment "A" to the Service Agreement to better reflect the services to be provided by CML; and

WHEREAS, the parties have, also, discovered that there is an error existing in Attachment "B" to the Service Agreement pertaining to compensation to Carell as set forth in subparagraphs 1.b.i. and ii. and wish to correct the same.

NOW, THEREFORE, for and in consideration of these premises and other good and valuable considerations, the receipt and sufficiency of which is hereby acknowledged, the parties hereto agree as follows:

1. The existing Attachment "A" to Service Agreement (October 1, 2009) is deleted in its entirety and substituted in lieu thereof a revised Attachment "A" to Service Agreement dated as of May 1, 2011, attached hereto.

2. The existing Attachment "B" to Service Agreement (October 1, 2009) is deleted in its entirety and substituted in lieu thereof a revised Attachment "B" to Service Agreement dated as of October 1, 2009, attached hereto.

3. All other terms and conditions of the Service Agreement not modified herein are ratified and remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed this First Amendment as of the day and year first above written.

"CL" **CareAll, LLC**

BY: _____
James W. Carell, Chief Manager/President

"CML" CareAll Management, LLC

BY: _____
J.W. Carell, Chief Manager/President

"Carell" _____
James W. Carell

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6/7/11

ATTACHMENT "A"
TO SERVICE AGREEMENT
(May 1, 2011)

SERVICES TO BE PROVIDED BY CML

Schedule 1: Reimbursement Services

A. CML shall arrange for the preparation of Agencies' annual Medicare cost report.

B. CML shall continuously review and monitor the setting of payment rates, calculate where necessary and submit such computations to the fiscal intermediary as required. CML shall prepare, or cause to be prepared, the appropriate reports, if any, to be filed with the fiscal intermediary.

C. CML shall negotiate on behalf of Agencies, unless Agencies choose to conduct such negotiations, any repayment schedules necessary in the event Agencies are overpaid by third-party payers and lacks sufficient funds for immediate repayment.

D. CML shall regularly analyze Agencies' visit statistics and mix of visits in relation to the prospective pay system to ensure optimum use of staffing and financial resources.

E. CML shall conduct on behalf of Agencies, unless Agencies choose to conduct such negotiations, any formal and/or informal appellate proceedings in regard to reasonableness determinations made by the fiscal intermediary in regard to the Agencies' Medicare cost report. Said proceedings may be pursued to the Proved Reimbursement Review Board level. Beyond that level, appellate proceedings much have the approval of Agencies and this shall also mean that the expenses associated with proceedings after the Provider Reimbursement Review Board shall be borne by Agencies.

F. CML shall perform, on a periodic basis, special studies to ensure that Agencies are taking advantage of every available option, election and alternative with which to legitimately maximize the amount of reimbursement received from third-party payer in accordance with applicable law and regulation.

G. CML may conduct all dealings with local representatives of the fiscal intermediary including, but not limited to, the following:

1) Entrance and exit conferences;
2) Repayment schedule;
3) Administrative reviews;
4) Appeal procedure up to the Provider Reimbursement review Board Stage

H. CML shall handle all dealings on behalf of Agencies, unless Agencies choose to conduct such dealings, with representatives of respective government agencies concerned with the administration of Title XVIII of the Social Security Act.

I. CMI shall advise Agencies on a regular basis of developments, legislative and otherwise, which may affect the operations of Agencies, e.g., certificate of need regulations, prospective reimbursement and National Health Insurance.

J. CML shall be responsible for collection and disbursement of all funds or monies, Medicare, Medicaid received by Agencies and maintain books and records in accordance with generally accepted principles.

K. All Funds received or generated by Agencies operations, shall be deposited by CML in a bank account(s) as designed by Agencies. Said accounts are defined as operating accounts, in the name of Agencies, out of which shall be disbursed all costs and expenses relative to the operation of Agencies. SMI shall periodically review Agencies' working capital needs to ensure Agencies remain financially viable at all times. Any and all checks or documents of withdrawal from the operating accounts may be signed by CML.

Schedule 2: Clinical/Operational Consulting Services

a. CML shall prepare and deliver a quarterly status report of the affairs of Agencies with specific commentary on the number of visits, personnel status and current events and/or developments impacting Agencies' operations, within thirty (30) days of the preceding calendar quarter to which fine status report relatives.

b. CML shall prepare and deliver an annual report describing the operations, policies and problems with respect to the Agencies covering in reasonable detail all aspects of Agencies. This report shall be delivered to Agencies within sixty (60) days of the preceding year or twelve (12) month period to which the report relates.

c. CML shall prepare and deliver such other reports as are reasonable, from time to time, requested by Agencies with regard to comparisons of Agencies to similar agencies and analysis of the relative efficiency of Agencies' various services.

d. CML shall interview for the position of Agencies" Administrator and make recommendation to Agencies' Owner based on interviewee's qualifications. All other positions in Agencies shall be hired by Agencies' Administrative or his or her designee.

e. CML shall periodically review the job related educational needs of Agencies' employees and shall schedule, organize and/or conduct such internal and/or external training programs and seminars as often as CML deems necessary, or at the request of Agencies for such training programs and seminars, to meet performance requirements for Agencies' employees.

f. CML shall prepare and submit for Agencies' approval, or review and revise, an Agencies' policies and procedure manual. The manual shall contain job descriptions for all categories of the Agencies' staff, general personnel policies and wage and salary scales. Proposals for adjustments to the wage and salary scales, whether necessitated by law or equity, shall be periodically submitted to Agencies for its study and recommendations.

g. CML shall maintain and, where possible, improve or upgrade Agencies' standards and procedures for admitting patients, and for collecting revenues from patients and/or third party payers. CML shall implement collection activities and shall ensure uniformity of charges to patients, regardless of his/her mode of payment.

h. CMI shall recommend and implement, subject to Agencies' approval, appropriate employee benefit programs. Employee benefits are defined as those benefits insuring to employees, such as profit-sharing and 401K pension plans, health and life insurance benefits, worker's compensation incentive plans for key employees, vacations and holidays.

i. CML shall assist the Agencies in establishing and maintaining ongoing community relations programs designed to assist the public with interpretation of Agencies' services and to foster good working relations with physicians and other providers within the health care community.

j. CML shall participate with Agencies at meetings, conventions, seminars and workshops related to the home health care field and/or specifically to Agencies, both on a local and national basis.

Schedule 3: Accounts Receivable/Billing/Purchasing/Computer Services

a. CML shall provide preparation, billing and collection of patient accounts. CML shall take all reasonable steps to ensure that all claims related to the production of revenue are processed on a timely basis, and in the format prescribed by servicing intermediaries. CML shall, institute on-line processing of claims, ADR's, etc. progressing to a totally paperless process.

b. CML shall enforce the rights of Agencies as a creditor under any contract or for the performance of any services, act as full power with the Agencies' intermediary for billing information, or correspondence to operate Agencies.

c. CML shall purchase, in accordance with approved purchasing policies, such medical supplies, solutions, equipment and vehicles (including leasing thereof), furniture, furnishings, materials and services (including service and maintenance contracts) which are deemed necessary to the efficient operations of Agencies. Purchases, single or cumulative, in excess of Five Thousand and 00/100 ($5,000.00) Dollars will require approval of an officer or designee of Agencies.

d. CML shall take all responsible steps to assure orderly and prompt payment of bills, accounts payable, employee payroll taxes, general taxes levies on Agencies and insurance premiums of Agencies. CML's responsibility under this section shall be limited to the exercise of due care and reasonable diligence to apply funds collected in the operation of

Agencies in a timely and prudent manner. CML does not assume the financial obligation for funding the payment of debts.

e. CMI shall provide local computer equipment and internal and external network capabilities along with telephone services to Agencies along with required periodic maintenance and upgrade of equipment and network services.

f. CMI shall have the authority to arrange for lease equipment when it appears to be in the best interest of Agencies and Agencies shall have the final approval of such contracts.

Schedule 4: Accounting / Risk Management Services

a. CML shall provide and maintain all risk management services to Agencies including worker's compensation coverage and general liability / professional liability insurance policies and provide for claims management / liaison with the Agencies and insurance carriers.

b. CML shall maintain an adequate chart of account, accounting systems, internal controls and such other, accounting and statistical data gathering systems as are necessary to comply with applicable laws and regulations.

c. CML shall ensure that proper inventories of all of Agencies' fixed and current assets are maintained on a current basis and that adequate controls are exercised to maintain the security of Agencies' assets.

d. CML shall establish and maintain an internal cost containment program designed to stimulate employee interest in controlling cost wherever practicable and to promote employee awareness of the need to contain costs through proper procedure, work methods and adherence to Agencies' established policies.

e. CML shall prepare and process the Agencies payrolls. Prepare and file all reports required by state and federal guidelines; quarterly state unemployment reports, 041's, 940's, W-2's, W-3's and 1099's.

f. CML shall prepare and deliver monthly financial statements containing a balance sheet and statement of income in conventional detail, within fifteen (15) days after the end of the proceeding calendar month to which the financial statement relates.

g. Not later than thirty (30) days prior to the commencement of each fiscal year. CML shall prepare and deliver to Agencies with respect to the following fiscal year:

(1) A capital expenditure budget outlining a program of capital expenditures for the next fiscal year. This budget shall designate proposed expenditures as either as either mandatory, desirable or optional;

(2) An operating budget setting forth an estimate of operating revenues and expenses for the next fiscal year. The budget shall be in conventional detail and shall contain narrative explanations of changes in utilization, rates, payroll and other factors differing significantly from the current year; and

(3) A projection of cash receipts and disbursements based upon the capital and operating budgets. This projection shall contain recommendations concerning the utilization of funds generated by excess cash flow or the need for temporary borrower where negative cash flow is anticipated.

SUPPLEMENTAL

ATTACHMENT "B"
TO SERVICE AGREEMENT
(October 1, 2009)

1. Management/Consulting Fees.

   a. Compensation to CML

      i. **Home Health Care.** Agency shall pay to CML six percent (6%) of its gross revenues generated from its home health are operations, payable monthly, on or before the fifteenth (15th) of each month based upon the preceding month's billings.

      ii. **Private Duty Care.** Agency shall pay to CML fifteen percent (15%) of its gross revenues generated less direct labor costs from its private duty care operations, payable monthly, on or before the fifteenth (15th) of each month based upon the preceding month's billings.

   b. Compensation to Carell (This represents total compensation to Carell as an officer of, and consultant to, CL, CML and the Agencies effective October 1, 2009.)

      i. **Home Health Care.** Agency shall pay to Carell twenty four percent (24%) of its gross revenues and five percent (5%) of its net profits before taxes generated from its home health care operations, payable monthly, on or before the fifteenth (15th) of each month based upon the preceding month's billings.

      ii. **Private Duty Care.** Agency shall pay to Carell five percent (5%) of its gross revenues less direct labor costs and five percent (5%) of its net profits generated from its home health care operations, payable monthly, on or before the fifteenth (15th) of each month based upon the preceding month's billings.

2. **OASIS (Outcomes and Assessment Information Sheet).** CML shall develop and implement a program to assure the Oasis collection mandate is being achieved and Agencies shall pay CML for keying and processing OASIS set as follows:

Start of Care Set -	$50.00 per set
Follow Up Set -	$25.00 per set
Transfer Set -	$15.00 per set
Discharge Set -	$25.00 per set

3. **Pre-Certification Fees.**

   a. One Hundred Seventy Five and 00/100 Dollars ($175.00) per new pre-certification episode.

   b. Eighty Seven and 50/100 Dollars ($87.50) per carryover episode.

4. **HHRG Nurse Consulting.** Ninety and 00/100 Dollars ($90.00) per hour.

5. **On Site Services.** In the event that Agencies request that CML personnel perform services for Agencies on site, including, but not limited to, services referred to in Paragraph 5 of the Service Agreement, Agencies agree to pay CML the following discounted hourly rates:

Classification	Hourly Rate	
Chief Operating Officer/President	$ 150.00	
Chief Financial Officer	125.00	
Audit/Compliance Specialist	100.00	
Reimbursement Specialist	100.00	
Professional Support Specialist	100.00	
Administrative Assistant	53.30	
ADRs	249.50	per request
Pre-Certification	175.00	per request
Episodic Carryover	87.50	

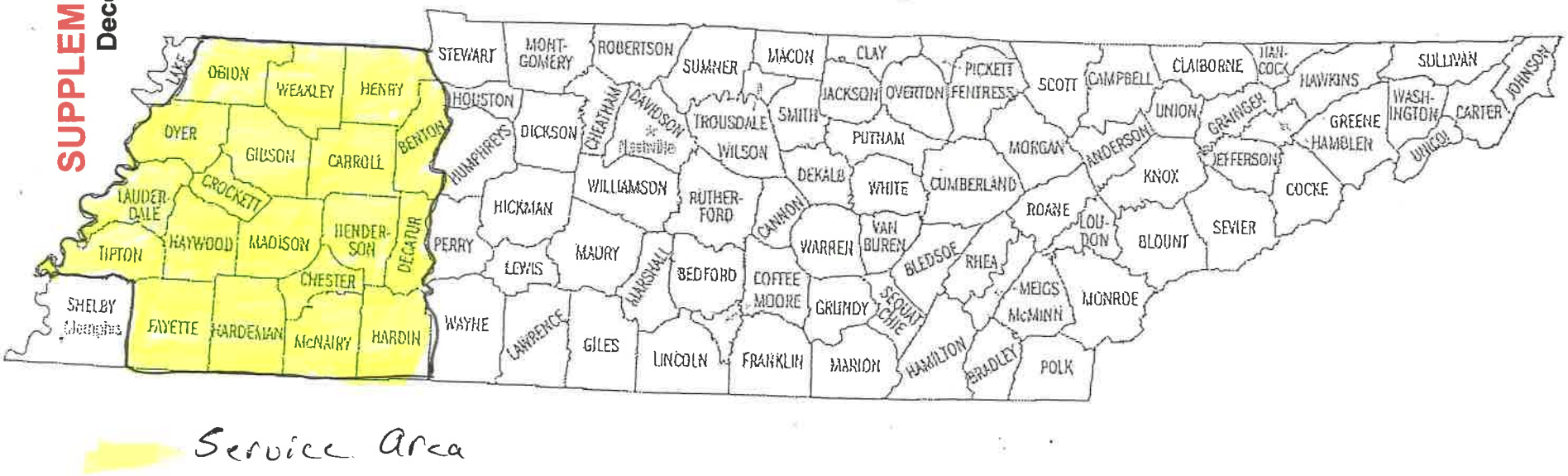
Travel expense shall be the per mile rate as established, from time to time, by agreement of CL and CML, in addition to lodging and food.

Note: If the total fees received by CML pursuant to Items 1-5, above, create a pre-tax profit for CML in excess of twenty percent (20%), CML shall pay to Carell an amount necessary to reduce CML's pre-tax profit to twenty percent (20%).

Attachment, Item 6- Section C, Need, Item 3
Service Area Map

SUPPLEMENTAL- # 1
December 27, 2013
9:45am

Professional Home Health Care, LLC
D/B/A CareAll Homecare Services



Service Area

Attachment, Item 7, Section C, Need, Item 4
Service Area Demographic Chart

7. **Section C, Need, Item 4. (Service Area Demographics)**

Please complete the following chart.

Demographic Data	19 County Service Area Total	State of TN Total
Total 2014 Population	649,388	6,470,546
Total 2018 Population	665,976	6,674,061
2014-2018 Population % Change	2% increase	3% increase
Age 65+ Pop. - 2014	102,825	931,676
Age 65 Pop.+ - 2018	113,291	1,044,909
Age 65+ Population % Change	9% increase	10% increase
Age 65+ Population % of Total Population	2014-16% 2018-17%	2014-14% 2018-16%
Median Household Income (Range)	31,099	42,453
TennCare Enrollees	114,430	1,203,220
TennCare Enrollees as % of Total Population	18%	19%
Persons Below Poverty Level	117,242.82	1,097,561.30
% of Total Population below Poverty Level	19%	17%

Attachment, Item 8, Section C, Need, Item 5
Service Area utilization Chart
other Home Health Agencies

SUPPLEMENTAL- # 1
December 27, 2013
9:45am

Agency	Base County	# of Service Area Counties Served	2010 Patients	2011 Patients	2012 Patients	'10-'12 % change
Tennessee Quality Homecare – Northwest	Benton	9	1,164	1,129	1,128	-3%
Baptist Memorial Home Care & Hospice	Carroll	10	245	235	213	-13%
Elk Valley Health Services, Inc.	Davidson	19	547	250	245	-55%
Home Care Solutions, Inc.	Davidson	19	2,140	2,192	2,080	-2%
Tennessee Quality Homecare – Southwest	Decatur	7	1,352	1,352	1,082	-19%
Volunteer Homecare of West Tennessee	Decatur	7	1,401	1,598	1,503	+6%
Regional Home Care – Dyersburg	Dyer	5	655	744	814	+19%
NHC Homecare	Fayette	7	254	254	217	-14%
Where the Heart Is	Fayette	2	34	253	271	+879%
NHC Homecare	Gibson	12	546	479	625	+12%
Volunteer Home Care, Inc.	Gibson	10	2,443	2,549	3,027	+19%
Amedisys Home Health	Hamilton	2	2,907	3,358	3,343	+13%
Deaconess Homecare II	Hardin	8	1,124	1,213	1,244	+9%
Hardin Medical Center Home Health	Hardin	4	308	252	274	-11%
Regional Home Care – Lexington	Henderson	12	683	578	616	-9%
Henry Co. Medical Center Home Health	Henry	4	474	355	399	-15%
St. Thomas Home Health (fka Hickman Community Home Care, Inc.)	Hickman	0	154	146	134	-12%
Amedisys Home Health Care	Madison	19	1,296	2,489	2,586	+99%
Extendicare Home Health of West Tennessee	Madison	19	1,015	962	993	-2%
Intrepid USA Healthcare Services	Madison	14	210	294	86	-60%
Medical Center Home Health	Madison	15	1,329	1,403	1,617	+17%
Regional Home Care – Jackson	Madison	19	969	1,206	1,061	-8%
Careall Homecare Services	Maury	3	354	285	224	-36%
NHC Homecare	Maury	1	2,150	2,212	2,134	-1%

SUPPLEMENTAL- # 1
December 27, 2013
9:45am

Extendicare Home Health of Western Tennessee	Obion	4	499	398	347	+30%
Magnolia Regional Health Care Home Hospice	Other (Corinth, MS)	2	26	39	53	+51%
Regional Home Care Parkway	Other (Fulton, KY)	2	23	14	14	+39%
Accredo Health Group, Inc.	Shelby	4	7	9	14	+7%
Alere Women's and Children's Health, LLC	Shelby	14	491	357	401	-18%
Amedisys Home Care (fka Tender Loving Care)	Shelby	2	789	882	938	+15%
Amedisys Home Health Care	Shelby	2	567	576	683	+16%
Amedisys Tennessee, LLC	Shelby	3	2,344	2,411	1,806	-22%
Americare Home Health Agency, Inc.	Shelby	0	1,097	1,324	1,727	+36%
Baptist Trinity Home Care	Shelby	2	3,314	3,248	3,367	-2%
Baptist Trinity Home Care – Private Duty	Shelby	0	1	1	1	—
Best Nurses, Inc.	Shelby	2	41	311	366	+88%
Extended Health Care, Inc. (fka Elder Care, Inc.)	Shelby	5	421	780	341	-19%
Family Home Health Agency	Shelby	1	1,070	375	863	-19%
Functional Independence Home Care, Inc.	Shelby	2	903	729	804	-10%
Home Health Care of West Tennessee, Inc.	Shelby	3	1,617	1,308	1,118	-30%
Homechoice Health Services	Shelby	5	2,963	2,887	1,788	-39%
Interim Healthcare of Memphis, Inc.	Shelby	2	727	720	689	+18%
Intrepid USA Healthcare Services	Shelby	2	537	662	615	+12%
Maxim Healthcare Services, Inc.	Shelby	4	82	103	197	+58%
Methodist Alliance Home Care	Shelby	6	3,352	3,226	3,180	-5%
No Place Like Home, Inc.	Shelby	2	48	38	55	+13%
Willowbrook Visiting Nurse Association	Shelby	3	451	473	533	+15%
Baptist Home Care & Hospice – Covington	Tipton	4	330	326	361	+8%
Careall Homecare Services	Tipton	19	1,424	1,491	1,103	-22%
Careall Homecare Services	Weakley	8	1,902	1,903	2,668	+28%

Attachment, Item 8, Section C, Need, Item 5
Service Area Utilization Chart
Applicant's Agency

SUPPLEMENTAL- # 1
December 27, 2013
9:45am

Please complete the following chart for your service area counties

Total Home Health Patients Trends by County of Residence

County	*2010 JAR Total residents served	*2011 JAR Total residents served	*2012 JAR Total residents served	'10-'12 % change
Benton	646	547	680	+ 5%
Carroll	1063	1,119	1224	+13%
Chester	491	490	565	+ 13%
Crockett	494	504	486	- 1%
Decatur	681	721	545	+ 7%
Dyer	1511	1,564	1,828	+ 17%
Fayette	765	766	631	- 17%
Gibson	1,864	1885	1961	+5%
Hardeman	854	797	804	- 5%
Hardin	940	1,012	1,035	+ 9%
Haywood	688	763	626	- 9%
Henderson	1,050	1,054	1055	+ .4%
Henry	1110	1,050	1,262	+ 12%
Lauderdale	980	934	793	- 20%
McNairy	1,040	1066	1038	- .1%
Madison	2,780	2979	3049	+ 8%
Obion	1,168	1,199	1400	+ 16%
Tipton	1,282	1,288	1067	+ 16%
Weakley	1,115	1,143	1241	+ 10%
TOTAL	20,524	20,931	21,139	+ 3%

**Data available in Summary JAR Report-Report 6*

9. **Section C, Need, Item 6. (Applicant's Historical and Projected Utilization)**

Your response to this item is noted. Please complete the following charts:

Attachment, Item 9, Section C, Need, Item 6
Applicant's Historical and Projected Utilization Chart

SUPPLEMENTAL- # 1
December 27, 2013
9:45am

County	2010 JAR Total patients served	2011 JAR Total patients served	2012 JAR Total patients served	2013 Total Projected Patients Served	2014 Total Projected Patients Served	2015 Total Projected Patients Served	2016 Total Projected Patients Served
Benton	0	1	0	0	0	0	0
Carroll	0	2	0	0	0	0	0
Chester	131	124	90	110	124	112	118
Crockett	193	193	173	163	118	107	112
Decatur	3	3	3	7	10	9	10
Dyer	10	7	9	2	0	0	0
Fayette	7	7	11	12	10	9	10
Gibson	52	54	46	82	84	76	80
Hardeman	148	153	160	172	156	141	148
Hardin	53	64	75	62	6	5	6
Haywood	247	285	233	257	252	227	238
Henderson	30	31	37	39	59	53	56
Henry	0	0	0	0	0	0	0
Lauderdale	225	226	202	233	235	212	223
McNairy	39	33	29	45	59	53	56
Madison	188	221	218	249	283	255	268
Obion	0	0	0	0	0	0	0
Tipton	98	87	75	127	112	101	106
Weakley	0	0	0	0	0	0	0
TOTAL	1,424	1,491	1,361	1,560	1,508	1,360	1,431

County	2010 JAR Total Visits	2011 JAR Total Visits	2012 JAR Total Visits	2013 Total Projected Visits	2014 Total Projected Visits	2015 Total Projected Visits	2016 Total Projected Visits
Benton							
Carroll							
Chester							
Crockett							
Decatur							
Dyer							
Fayette							
Gibson							
Hardeman							
Hardin							
Haywood							
Henderson							
Henry							
Lauderdale							
McNairy							
Madison							
Obion							
Tipton							
Weakley							
TOTAL							

Attachment, Item 10 -Section C,
Economic Feasibility Item 4
Revised Historical Data Chart and Projected Data Chart

ISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January (Month).

	Year 2010	Year 2011	Year 2012
A. Utilization Data (Specify unit of measure) (visits)	78,390	70,478	47,769
B. Revenue from Services to Patients	$	$	$
1. Inpatient Services	20,471,904	18,600,263	16,198,731
2. Outpatient Services			
3. Emergency Services			
4. Other Operating Revenue (Specify)_____			
Gross Operating Revenue	$20,471,904	$18,600,263	$16,198,731
C. Deductions from Gross Operating Revenue	$	$	$
1. Contractual Adjustments			
2. Provision for Charity Care			
3. Provisions for Bad Debt			
Total Deductions	$ 0	$ 0	$ 0
NET OPERATING REVENUE	$20,471,904	$18,600,263	$16,198,731
D. Operating Expenses			
1. Salaries and Wages	$ 7,674,036	$ 6,850,487	$ 6,482,351
2. Physician's Salaries and Wages	145,821	141,621	137,953
3. Supplies	578,616	619,183	1,298,265
4. Taxes	9,624	26,811	30,069
5. Depreciation	136,434	134,760	131,880
6. Rent			
7. Interest, other than Capital			
8. Management Fees:			
a. Fees to Affiliates	4,826,832	4,572,713	3,834,542
b. Fees to Non-Affiliates			
9. Other Expenses – Specify on separate page #12	1,633,869	1,364,467	1,040,870
Total Operating Expenses	$15,005,232	$13,710,042	$12,958,986
E. Other Revenue (Expenses) – Net (Specify) see pg. 12	$ 135,513	$(1,009,394)	$(3,113,386)
NET OPERATING INCOME (LOSS)	$5,602,185	$3,880,827	$ 126,359
F. Capital Expenditures	$	$	$
1. Retirement of Principal			
2. Interest			
Total Capital Expenditures	$ 0	$ 0	$ 0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$5,602,185	$3,880,827	$ 126,359

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

		Year 2015	Year 2016
A.	Utilization Data (Specify unit of measure) (visits)	41,398	42,226
B.	Revenue from Services to Patients		
	1. Inpatient Services	$	$
	2. Outpatient Services	11,188,573	11,412,345
	3. Emergency Services		
	4. Other Operating Revenue (Specify)_____		
	Gross Operating Revenue	$ 11,188,573	$ 11,412,345
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$	$
	2. Provision for Charity Care		
	3. Provisions for Bad Debt		
	Total Deductions	$ 0	$ 0
	NET OPERATING REVENUE	$ 11,188,573	$ 11,412,345
D.	Operating Expenses		
	1. Salaries and Wages	$ 5,716,390	$ 5,773,554
	2. Physician's Salaries and Wages		
	3. Supplies	86,196	87,058
	4. Taxes	563,394	569,028
	5. Depreciation	25,623	25,879
	6. Rent	94,460	94,460
	7. Interest, other than Capital		
	8. Management Fees:		
	a. Fees to Affiliates	2,144,284	2,187,169
	b. Fees to Non-Affiliates		
	9. Other Expenses – Specify on separate page 14	1,220,318	1,233,222
	Total Operating Expenses	$ 9,850,665	$ 9,970,310
E.	Other Revenue (Expenses) -- Net (Specify) Bad Debts	$ (206,990)	$ (211,130)
	NET OPERATING INCOME (LOSS)	$ 1,130,918	$ 1,230,845
F.	Capital Expenditures		
	1. Retirement of Principal	$	$
	2. Interest		
	Total Capital Expenditures	$ 0	$ 0

NET OPERATING INCOME (LOSS)	$1,130,918	$1,230,845
LESS CAPITAL EXPENDITURES		

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2010	Year 2011	Year 2012
1. Auto & Mileage	$315,190	$289,899	$214,542
2. Employee Benefits	299,534	271,970	185,038
3. Insurance	245,961	232,516	251,291
4. Contract Services	174,998	180,659	14,905
5. Phone/Utilities	99,181	90,713	72,328
6. Advertising	73,694	104,401	113,938
7. Other Administrative	425,311	194,309	188,828
Total Other Expenses	$1,633,869	$1,364,467	$1,040,870
OTHER REVENUE (EXPENSES)			
Bad Debts		(1,196,562)	
Miscellaneous Income	110,380	171,795	
Interest Income	25,133	15,373	19,947
Legal Settlement			(3,133,333)
	135,513	(1,009,394)	(3,113,386)

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2015	Year 2016
1. Auto & Mileage	$148,725	$150,212
2. Employee Benefits	222,839	225,067
3. Insurance	268,004	270,684
4. Contract Services	103,495	105,565
5. Phone/Utilities	74,606	75,017
6. Advertising	97,707	98,684
7. Other Administrative	304,942	307,993
Total Other Expenses	$1,220,318	$1,233,422

Attachment, Item 14 –Proof of Publication
Affidavit of Publication

SUPPLEMENTAL- # 1
December 27, 2013
9:45am

0101703740

Affidavit of Publications

Newspaper: Jackson Sun 7 Dav

State Of Tennessee

TEAR SHEET ATTACHED

Account Number: 301106JS
Advertiser: CAREALL HOMECARE SERVICES

RE: NOTIFICATION OF INTENT

I, V Perry **Sales Assistant** for the above mentioned newspaper, hereby certify that the attached advertisement appeared in said newspaper on the following dates:

12/9/2013 V Perry

Subscribed and sworn to me this 12 day of Dec., 2013

Lela Bates
NOTARY PUBLIC

LELA BATES
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
MY COMMISSION EXPIRES 5/5/15

SUPPLEMENTAL- # 1
December 27, 2013
9:45am

TODAY'S CROSSWORD PUZZLE

Sponsored by West Tennessee Healthcare
www.wth.org

PREVIOUS PUZZLE SOLVED

Want more puzzles? Check out the "Just Right Crossword Puzzles" books at QuillDriverBooks.com

Play online at jacksonsun.com/crossword

4000

Public Notices

0101702471
SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on January 9, 2014 at 10:00AM local time, at the north entrance of the Madison County Courthouse, 100 E. Main Street, Jackson, TN 38301, conducted by Shapiro & Kirsch, LLP Substitute Trustee, pursuant to Deed of Trust executed by Patricia Hunt, his wife and Johnny W. Hunt, to Randall Ray, Trustee, on April 20, 2000 at Book T1240, Page 210, all of record in the Madison County Register's Office.

Party entitled to enforce security interest: Bank of America, National Association as successor by merger to LaSalle Bank National Association ("Assignee"), formerly known as LaSalle National Bank, in its capacity as indenture trustee under that certain Sale and Servicing Agreement dated June 1, 2000 among AFC Trust Series 2000-2, as Issuer, Superior Bank FSB, as Seller and Servicer, and LaSalle Bank National Association, as Indenture Trustee, AFC Mortgage Loan Asset Backed Notes, Series 2000-2, and any amendments thereto, its successors and assigns

The following real estate located in Madison County, Tennessee, will be sold to the highest call bidder subject to all unpaid taxes, prior liens and encumbrances of record:

BEGINNING at a point in the north margin of Brooks Drive, said point is the southwest corner of Lot No. 4 of the Forest Hills Subdivision as recorded in Plat Book 2, Page 156 in the Register's Office of Madison County, Tennessee, thence North 2 degrees East with the west line of Lot No. 4 a distance of 120 feet to a point; thence North 88 degrees West a distance of 122 feet to a point the southeast corner of Lot No. 2; thence South 25 degrees East with the east line of Lot No. 2 a distance of 116.8 feet to the north margin of Brooks Drive; thence easterly with the north margin of Brooks Drive a distance of 71 feet to the point of beginning. Being Lot No. 3 of the aforesaid platted Subdivision. This description was written from the recorded plat. Survey by McRae Engineering, Inc., License No. 430332-347

Street Address: 29 North Brooks Drive, Jackson, Tennessee 38301

Secondary Property Address: 29 Brooks Drive, Jackson, TN 38301

Parcel Number: 078C D 008.00

Current Owner(s) of Property: Johnny W. Hunt and wife, Patricia Hunt, as tenants by the entirety

The street address of the above described property is believed to be 29 North Brooks Drive, Jackson, Tennessee 38301, but such address is not part of the legal description of the property sold herein and in the event of any discrepancy, the legal description referenced herein shall control.

SALE IS SUBJECT TO TENANT(S) RIGHTS IN POSSESSION.

All right of equity of redemption, statutory and otherwise, and homestead are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee.

If you purchase a property at the foreclosure sale, the entire purchase price is due and payable at the conclusion of the auction in the form of a certified/bank check made payable to Shapiro & Kirsch, LLP. No personal checks will be accepted. To this end, you must bring sufficient funds to outbid the lender and any other bidders. Insufficient funds will not be accepted. Amounts received in excess of the winning bid will be refunded to the successful purchaser at the time the foreclosure deed is delivered.

This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. This sale may be rescinded at any time.

Shapiro & Kirsch, LLP Substitute Trustee
www.auction.com
Law Office of Shapiro & Kirsch, LLP
555 Perkins Road Extended, Second Floor
Memphis, TN 38117
Phone (901)767-5566
Fax (901)761-5690
File No. 13-064357

NOTIFICATION OF INTENT
TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that: Professional Home Health Care, LLC D/B/a CareAll Homecare Home Health Agency owned by: CareAll, LLC with an ownership type of a Limited Liability Company and to be managed by: CareAll Management, LLC intends to file an application for a Certificate of Need for: The relocation of its principle office from 901 Highway 51 South, Covington, Tipton County, Tennessee to the current location of its Brownsville branch office, 1151 Tamarbell Street, Brownsville, Haywood County, Tennessee.

Professional Home Health Care, LLC is licensed to serve Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lauderdale, McNairy, Madison, Obion, Tipton, and Weakley counties. Existing home care services will not be effected, and no service will be initiated or discontinued. The project does not impact patient care, involves no construction or capital expenditure or the acquisition or modification of any item of major medical equipment. Anticipated cost $59,300.

The anticipated date of filing the application is: December 13, 2013. The contact person for the project is Mary Ellen Foley, Project Director who may be reached at: CareAll Management, LLC, 326 Welch Road, Nashville, Tennessee, 37211. 615-331-6137.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

The published Letter of Intent must contain the following statement pursuant to TCA Sec. 68-11-1607(c)(1): (A) any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled, and (B) any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

THE ACES ON BRIDGE®

Bobby Wolff

Sponsored by West Tennessee Healthcare

WONDERWORD

By DAVID OUELLET

HOW TO PLAY: All the words listed below appear in the puzzle — horizontally, vertically, diagonally, even backward. Find them and CIRCLE THEIR LETTERS ONLY. DO NOT CIRCLE THE WORD. The leftover letters spell the Wonderword.

APPSCRIPTIONS — Solution: 10 letters

S	C	E	H	A	N	T	I	B	S	T	S	E	T	O
D	G	O	G	T	T	R	O	P	E	R	S	P	D	N
S	E	N	M	A	N	I	O	E	B	E	E	A	O	L
R	E	T	U	P	M	O	C	E	O	N	N	I	C	I
D	E	E	E	L	L	I	M	K	D	D	T	N	T	N
S	G	L	T	N	V	I	A	E	Y	I	I	I	O	E
N	N	B	P	R	T	D	A	G	D	S	F	T	R	G
E	I	I	E	P	V	I	O	N	S	I	E	R	N	P
S	N	S	M	I	A	L	O	E	C	Y	C	I	E	L
T	I	S	C	P	O	C	N	N	R	E	R	I	C	E
E	M	E	K	N	R	L	M	A	N	A	G	E	N	H
L	A	C	H	I	L	O	I	R	E	M	O	T	E	E
B	X	C	S	E	N	D	V	H	S	M	R	A	L	A
A	E	A	W	A	R	E	N	E	S	S	Y	A	D	R
T	N	E	M	T	A	E	R	T	R	A	C	K	S	T

Accessible, Advice, Alarms, Apple, Awareness, Body, Compliance, Computer, Condition, Days, Detention, Diary, Doctor, Examining, Fitness, Free, Hearing, Heart, Help, Image, Improve, Keep, Lungs, Manage, Medicine, Month, Note, Online, Pain, Remote, Report, Send, Sensors, Service, Skin, Tablets, Technology, Tests, Tracks, Treatment, Trend, Wellness

Last Saturday's Answer: Broadcasting

To purchase WONDERWORD books, visit wonderword.universaluclick.com or call 1-800-642-6480.

Sponsored by West Tennessee Healthcare

Attachment-Item 15-Project Completion Forecast Revised Chart

SUPPLEMENTAL- # 1
December 27, 2013
9:45am

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in T.C.A. § 68-11-1609(c): February 26, 2014

Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

Phase	DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1. Architectural and engineering contract signed	NA	NA
2. Construction documents approved by the Tennessee Department of Health	NA	NA
3. Construction contract signed	NA	NA
4. Building permit secured	NA	NA
5. Site preparation completed	NA	NA
6. Building construction commenced	NA	NA
7. Construction 40% complete	NA	NA
8. Construction 80% complete	NA	NA
9. Construction 100% complete (approved for occupancy	NA	NA Renewal
10. *Issuance of license	NA	01/22/2014
11. *Initiation of service	3	03/01/2014
12. Final Architectural Certification of Payment	NA	NA
13. Final Project Report Form (HF0055)		03/01/2014

* **For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

Note: **If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.**

DEC 27 '13 AM 9:35

SUPPLEMENTAL

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Weakley

NAME OF FACILITY: Professional Home Health Care, LLC D/B/A Care All Homecare Services

I, Mary Ellen Foley, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Mary Ellen Foley
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 23rd day of December, 2013, witness my hand at office in the County of Weakley, State of Tennessee.

Tammy Marie Hazlewood
NOTARY PUBLIC

My commission expires May 24, 2017.

TAMMY MARIE HAZLEWOOD
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF WEAKLEY
My Commission Expires May 24, 2017

HF-0043

Revised 7/02

SUPPLEMENTAL - #2
-ORIGINAL-

Professional Home Health Care
d/b/a CareAll Homecare Services

CN1312-049

SUPPLEMENTAL #2
December 30, 2013
11:14 am

CareAll
Home Care Services

December 30, 2013

Mr. Mark A. Farber
Deputy Director
State of Tennessee Health Services and Development Agency
Andrew Jackson State Office Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Re: Certificate of Need Application CN1312-049
Professional Home Health Care, LLC d/b/a CareAll Homecare Services

Dear Mr. Farber,

We are in receipt of your letter dated December 27, 2013 requesting additional clarification or additional discussion. Please find enclosed a copy of your letter and our responses. Due to the time sensitive nature of getting you this information I am submitting the enclosed Affidavit as lawful agent. The project director Ms. Mary Ellen Foley is on vacation. She remains primary contact if additional questions arise or information is needed.

Sincerely,

Lynn Forte, CPA
Controller
CareAll Homecare Services

SUPPLEMENTAL #2
December 30, 2013
11:14 am

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Haywood

NAME OF FACILITY: Professional Home Health Care, LLC
DBA CareAll Home Care Services

I, Lynn Forte, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Lynn Forte / Controller
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 30 day of Dec, 2013, witness my hand at office in the County of Davidson State of Tennessee.

C. LAWRENCE
STATE OF TENNESSEE NOTARY PUBLIC
WILSON COUNTY

NOTARY PUBLIC

My commission expires May 14, 2017.

HF-0043

Revised 7/02

SUPPLEMENTAL #2
December 30, 2013
11:14 am

Requested Additional information, CON Application, Professional Home Health Care, LLC D/B/A CareAll Homecare Services

1. *Section B, Project Description, item IID*
   Please explain what a CBSA is.
   Response: See attached description of a Core Based Statistical Area.

2. *Section C, Need, item 4.(Service area demographics)*
   Your response to this item is noted. It appears you have used the 2008 revision to population projections that is based on the 2000 census. The Department of Health, Division of Health Statistics now has a 2013 revision based on 2010 Census. Please contact the Department of Health, Division of Health Statistics for these updated projections.
   Response: See attached revised chart using the 2013 revision from the Division of Health statistics.

3. Section C, need, Item 6. (Applicant's Historical and Projected Utilization)
   With respect to the applicant's chart of patients by county, for 2012 the applicant has displayed 160 patients for Hardeman and 202 patients for Lauderdale; however the applicant's JAR displays 48 patients for Hardeman and 56 patients for Lauderdale. Please address the discrepancy.
   Response: In preparing this report, the submitted JAR reports were reviewed and these two errors were found. I rechecked the patient totals with our records and corrected the patient totals in this report.

4. *Section C, Economic feasibility, Item 4. (Historical Data Chart)*
   There appears to be a calculation error in the year 2012 column. Please make the necessary corrections and submit a revised Historical Data Chart.
   Response: See revised chart.

SUPPLEMENTAL #2
December 30, 2013
11:14 am

Attachment Section B, Project Description, Item IID

CBSA Description

Core Based Statistical Area

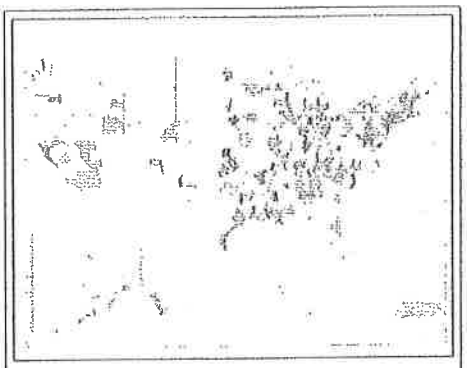
From Wikipedia, the free encyclopedia

See also: List of United States core based statistical areas

A **Core Based Statistical Area (CBSA)** is a U.S. geographic area defined by the Office of Management and Budget (OMB) based around an urban center of at least 10,000 people and adjacent areas that are socioeconomically tied to the urban center by commuting. Areas defined on the basis of these standards applied to Census 2000 data were announced by OMB in June 2003. These standards are used to replace the definitions of metropolitan areas that were defined in 1990. The OMB released new standards based on the 2010 Census on February 28, 2013.[1][2]

The term "CBSA" refers collectively to both metropolitan statistical areas and micropolitan areas. Micropolitan areas are based around Census Bureau-defined urban clusters of at least 10,000 and fewer than 50,000 people. The map below shows the metropolitan areas (medium green) and micropolitan areas (in light green) for the CBSAs for the United States and Puerto Rico.

The basic definition of metropolitan areas has had slight changes made to it as well. A metropolitan area, as it did in 1990, requires a Census Bureau-defined urbanized area of at least 50,000 people. A metropolitan statistical area containing an urbanized area of at least 2.5 million people can be subdivided into two or more "metropolitan divisions," provided specified criteria are met. Metropolitan divisions are conceptually similar to the primary metropolitan statistical areas (PMSAs) defined under previous standards.



An enlargeable map of the 124 Combined Statistical Areas of the United States

By a similar token, there are now definitions for "Combined Statistical Areas" (CSA). These areas can be formed when adjoining CBSAs meet particular standards to become new areas. It does not matter which kind of areas they are; any combination of metro and micro areas may be used to form a CSA.

Unlike past years, the traditional listings of metropolitan areas list New England regions as county-based areas. In the past, these were referred to by the Census as "NECMA"'s (New England County Metropolitan Areas) and were separate from the normal census counts for the areas, which used cities and towns as their basis. They have essentially swapped places now, with the city and town areas (or NECTAs for New England City and Town Areas) being the separate listings.

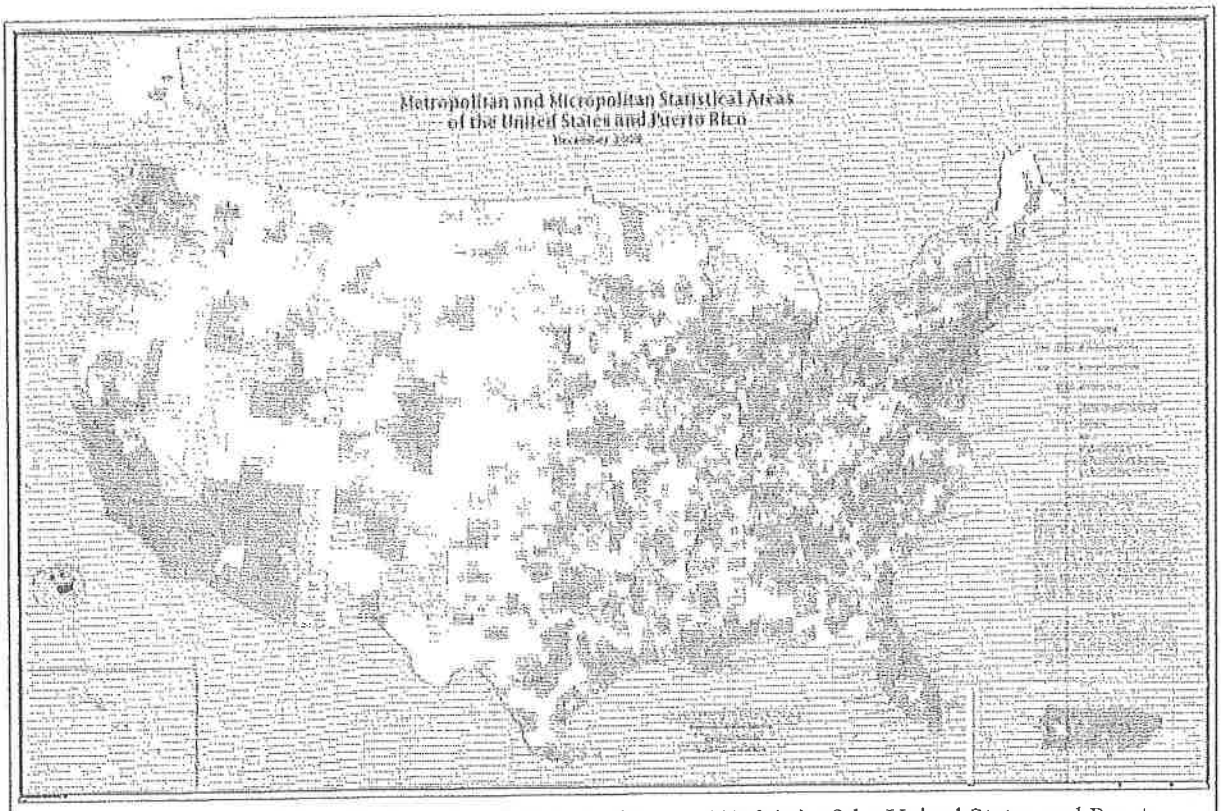
An enlargeable map of the NECTA Divisions of the US

Despite there not being much change in the basic definition, 49 new metropolitan areas were formed as a result of the new rules for them. Over 550 other areas were classified as micropolitan. All told, the present rules have defined 935 CBSAs in the U.S. and Puerto Rico. 11 of the CBSAs have metropolitan

divisions, 29 in total. In comparison, the definition of metropolitan areas in 1999, the last year areas were formed based on the 1990 rules for them, there were 284 metropolitan areas, with 19 of the areas providing 76 primary metropolitan areas (the equivalent of divisions); almost three times the number of areas overall are now recognized by the OMB.

Contents

Map



An enlargeable map of the 955 Core Based Statistical Areas (CBSAs) of the United States and Puerto Rico. The 374 Metropolitan Statistical Areas (MSAs) are shown in medium green. The 581 Micropolitan Statistical Areas (μSAs) are shown in light green.

See also

- United States of America

- Outline of the United States
- Index of United States-related articles
- Book:United States

- Demographics of the United States
  - United States Census Bureau
    - List of U.S. states and territories by population
    - List of metropolitan areas of the United States
    - List of United States cities by population
    - List of United States counties and county-equivalents
  - United States Office of Management and Budget
    - The OMB has defined 1098 statistical areas comprising 388 MSAs, 541 μSAs, and 169 CSAs
      - Primary statistical area – List of the 574 PSAs
        - Combined Statistical Area – List of the 169 CSAs
        - Core Based Statistical Area – List of the 929 CBSAs
          - Metropolitan Statistical Area – List of the 388 MSAs
          - Micropolitan Statistical Area – List of the 541 μSAs

References

1. ^ "GreatData.com" (http://greatdata.com). Retrieved 22 March 2013.
2. ^ "OMB" (http://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b13-01.pdf). Retrieved 22 March 2013.

External links

- United States Government (http://www.usa.gov/)
  - United States Census Bureau (http://www.census.gov/)
    - 2010 United States Census (http://2010.census.gov/2010census/)
    - USCB population estimates (http://www.census.gov/popest/data/index.html)
  - United States Office of Management and Budget (http://www.whitehouse.gov/omb/)

Categories: Core based statistical areas of the United States | Demographics of the United States | United States Census Bureau geography

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SUPPLEMENTAL #2
December 30, 2013
11:14 am

Attachment Section C, Need, Item 4
Revised Chart

SUPPLEMENTAL #2
December 30, 2013
11:14 am

7. Section C, Need, Item 4. (Service Area Demographics)

Please complete the following chart.

Demographic Data	19 County Service Area Total	State of TN Total
Total 2014 Population	4.23,211	6,588,698
Total 2018 Population	636,474	6,833,509
2014-2018 Population % Change	+2%	+3%
Age 65+ Pop. - 2014	106,247	981,984
Age 65 Pop.+ - 2018	115,225	1,102,413
Age 65+ Population % Change	9% increase	10.9% increase
Age 65+ Population % of Total Population	2014- 17% 2018- 18%	2014 - 15% 2018- 16%
Median Household Income (Range)	31,099	42,453
TennCare Enrollees	114,430	1,203,220
TennCare Enrollees as % of Total Population	18%	18%
Persons Below Poverty Level	117,242,82	1,097,561.30
% of Total Population below Poverty Level	19%	17%

2013 revised Health Statistics

SUPPLEMENTAL #2
December 30, 2013
11:14 am

Attachment Section C, Economic Feasibility, Item 4. (Historical Data Chart)

Revised Chart

SUPPLEMENTAL #2
December 30, 2013
11:14 am

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January (Month).

	Year 2010	Year 2011	Year 2012
A. Utilization Data (Specify unit of measure) (visits)	78,390	70,478	47,769
B. Revenue from Services to Patients			
1. Inpatient Services	$	$	$
2. Outpatient Services	20,471,904	18,600,263	16,198,731
3. Emergency Services			
4. Other Operating Revenue (Specify)_____			
Gross Operating Revenue	$20,471,904	$18,600,263	$16,198,731
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	$	$	$
2. Provision for Charity Care			
3. Provisions for Bad Debt			
Total Deductions	$	$	$
NET OPERATING REVENUE	$20,471,904	$18,600,263	$16,198,731
D. Operating Expenses			
1. Salaries and Wages	$7,674,036	$6,850,487	$6,482,351
2. Physician's Salaries and Wages			
3. Supplies	145,821	141,621	137,953
4. Taxes	578,616	619,183	1,298,265
5. Depreciation	9,624	26,811	30,069
6. Rent	136,434	134,760	131,880
7. Interest, other than Capital			3,056
8. Management Fees:			
a. Fees to Affiliates	4,826,832	4,572,713	3,834,542
b. Fees to Non-Affiliates			
9. Other Expenses (Specify) _____	1,633,869	1,364,467	1,040,870
Total Operating Expenses	$15,005,232	$13,710,042	$12,958,986
E. Other Revenue (Expenses) – Net (Specify)	$135,513	$(1,009,394)	$(3,113,386)
NET OPERATING INCOME (LOSS)	$5,602,185	$3,880,827	$126,359
F. Capital Expenditures			
1. Retirement of Principal	$	$	$
2. Interest			
Total Capital Expenditures	$ ~~0~~	$ ~~0~~	$ ~~0~~
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$5,602,185	$3,880,827	$126,359

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

		Year 2015	Year 2016
A.	Utilization Data (Specify unit of measure) (visits)	41,398	42,226
B.	Revenue from Services to Patients		
	1. Inpatient Services	$	$
	2. Outpatient Services	11,188,573	11,412,345
	3. Emergency Services		
	4. Other Operating Revenue (Specify)_____		
	Gross Operating Revenue	$ 11,188,573	$ 11,412,345
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$	$
	2. Provision for Charity Care		
	3. Provisions for Bad Debt		
	Total Deductions	$ 0	$ 0
NET OPERATING REVENUE		$ 11,188,573	$ 11,412,345
D.	Operating Expenses		
	1. Salaries and Wages	$ 5,716,390	$ 5,773,554
	2. Physician's Salaries and Wages		
	3. Supplies	86,196	87,058
	4. Taxes	563,394	569,028
	5. Depreciation	25,623	25,879
	6. Rent	94,460	94,460
	7. Interest, other than Capital		
	8. Management Fees:		
	a. Fees to Affiliates	2,144,284	2,187,169
	b. Fees to Non-Affiliates		
	9. Other Expenses – Specify on separate page 14	1,220,318	1,233,222
	Total Operating Expenses	$ 9,850,665	$ 9,970,370
E.	Other Revenue (Expenses) -- Net (Specify) Bad Debts	$ (206,990)	$ (211,130)
NET OPERATING INCOME (LOSS)		$ 1,130,918	$ 1,230,845
F.	Capital Expenditures		
	1. Retirement of Principal	$	$
	2. Interest		
	Total Capital Expenditures	$ 0	$ 0

NET OPERATING INCOME (LOSS)	$1,130,918	$1,230,845
LESS CAPITAL EXPENDITURES		

SUPPLEMENTAL #2
December 30, 2013
11:14 am

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2010	Year 2011	Year 2012
1. Auto & Mileage	$315,190	$289,899	$214,542
2. Employee Benefits	299,534	271,970	185,038
3. Insurance	245,961	232,516	251,291
4. Contract Services	174,998	180,659	14,905
5. Phone/Utilities	99,181	90,713	72,328
6. Advertising	73,694	104,401	113,938
7. Other Administrative	425,311	194,309	188,828
Total Other Expenses	$1,633,869	$1,364,467	$1,040,870
OTHER REVENUE (EXPENSES)			
Bad Debts		(1,196,562)	
Miscellaneous Income	110,380	171,795	
Interest Income	25,133	15,373	19,947
Legal Settlement			(3,133,333)
	135,513	(1,009,394)	(3,113,386)

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2015	Year 2016
1. Auto & Mileage	$148,725	$150,212
2. Employee Benefits	222,839	225,067
3. Insurance	268,004	270,684
4. Contract Services	103,495	105,565
5. Phone/Utilities	74,606	75,017
6. Advertising	97,707	98,684
7. Other Administrative	304,942	307,993
Total Other Expenses	$1,220,318	$1,233,222

State of Tennessee
Health Services and Development Agency
Andrew Jackson State Office Building, 9th Floor
502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

December 27, 2013

Mary Ellen Foley
Project Director
CareAll Management, LLC
326 Welch Road
Nashville, TN 37211

RE: Certificate of Need Application CN1312-049
Professional Home Health Care, LLC d/b/a CareAll Homecare Services

Dear Ms. Foley,

This will acknowledge our December 27, 2013 receipt of your application for a Certificate of Need for the relocation of the parent office of Professional Home Health Care, LLC d/b/a CareAll Homecare Services, an established home care organization (home health agency), from 901 Highway 51 South, Covington, (Tipton County), TN to the current location of its Brownsville branch office at 1151 Tammbell Street, Brownsville (Haywood County), TN.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 noon, Monday, December 30, 2013. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

---

1. **Section B, Project Description, Item IID**

   Please explain what a CBSA is.

2. **Section C, Need, Item 4. (Service Area Demographics)**

   Your response to this item is noted. It appears you have used the 2008 revision to population [projections that is based on the 2000 census. The Department of Health, Division of Health Statistics now has a 2013 revision based on the 2010 Census. Please contact the Department of Health, Division of Health Statistics for these updated projections.

3. **Section C, Need, Item 6. (Applicant's Historical and Projected Utilization)**

   With respect to the applicant's chart of patients by county, for 2012 the applicant has displayed 160 patients for Hardeman and 202 patients for Lauderdale; however the applicant's JAR displays 48 patients for Hardeman and 56 patients for Lauderdale.

   Please address this discrepancy.

4. **Section C, Economic Feasibility, Item 4. (Historical Data Chart)**

   There appears to be a calculation error in the Year 2012 column. Please make the necessary corrections and submit a revised Historical Data Chart.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is February 14, 2014. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ɜ 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please contact this office.

Sincerely,

Mark A. Farber
Deputy Director

Enc.